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MEDICARE AND MEDICAID

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

JANUARY 29, 1987

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MEDICARE AND MEDICAID

THURSDAY, JANUARY 29, 1987

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:33 a.m. in Room SD-215, Dirksen Senate Office Building, the Honorable George J. Mitchell (chairman) presiding.

Present: Senators Mitchell, Baucus, Rockefeller, Danforth, Chafee, Heinz and Durenberger.

[The press release announcing the hearing and the prepared written statement of Senators Heinz and Rockefeller follow:]

[PRESS RELEASE]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARINGS ON MEDICARE AND MEDICAID PROGRAMS

Washington, D.C.—The Honorable George J. Mitchell (D., Me.), Chairman, announced today that the Subcommittee on Health of the Senate Finance Committee will hold a hearing on Thursday, January 29, 1987 on an overview of the Medicare and Medicaid programs, focusing on the impact of budget policy over the past six years, and possibilities for future program changes.

The Subcommittee will examine how the Medicare and Medicaid programs have been affected by deficit reduction efforts and structural changes, whether there have been any adverse effects on quality of care or access to care as a result of those efforts and changes, and whether there exist specific program areas where further budget cuts are justified or where reimbursement or coverage needs to be increased in order to preserve quality and access. The Subcommittee also will examine budget and program structure changes proposed by the President in the fiscal year 1988 budget.

The hearing will begin at 9:30 A.M. on Thursday, January 29, 1987 in Room SD-215 of the Dirksen Senate Office Building.

The Subcommittee will receive testimony from invited witnesses only. A list of the witnesses follows.

Future hearings will be announced later at which time the views of witnesses representing beneficiaries, health care providers and others will be heard with respect to the fiscal year 1988 budget.

OPENING STATEMENT BY SENATOR JOHN HEINZ (R-PA)
FINANCE COMMITTEE SUBCOMMITTEE ON HEALTH HEARING
29 JANUARY 1987

Thank you Mr. Chairman. I am very pleased that this Subcommittee has chosen for its first hearing to look at the effects of six years of budget and other policy changes on Medicare and Medicaid. I also would like to commend the Chairman for assembling such a distinguished panel of witnesses. Without a doubt, we have some of the best minds in the country here today to help us understand the past, present and future of these two critical National health care programs.

It is imperative that we grapple with the effects of the recent budgetary constraints, as well as the changes in Medicare and Medicaid themselves, on the level of health care being provided by the two programs. In particular, we must determine whether the recent budget cuts and changes in Medicare and Medicaid have led to reductions in quality and access to care. One area of recent innovation which must be studied is the effect of Medicare's new system for reimbursing hospitals, the Prospective Payment Systems. Some studies have suggested that earlier discharges and the placement of patients in appropriate post-hospital settings have been the result of PPS. The need for further study into the effects of PPS is certainly warranted.

The Medicare and Medicaid systems were established to provide a safety net of medical coverage for all Americans, but recent system changes, combined with shifting political priorities--reflected in the recent budgetary constraints--could deprive many Americans of the coverage they expect and deserve. Already we see too many cases of individuals whose medical costs have been shifted from the Federal coffers to private pockets. We need to determine whose pockets are being tapped and whether the burden on beneficiaries is eroding access.

We also need to look at the expanded burden for health coverage that has shifted from the Federal government to employers. We need to determine not only what impact these additional health care costs have had on all employers, but whether small employers can and should be able bear these potentially enormous costs. Certainly there is the danger that these shifting costs may dampen interest in employing older workers.

These issues only scratch the surface of the many questions and problems this Subcommittee will be addressing this year. I know my colleagues share my interest in hearing what these experts have to say about other issues such as the need for expanded coverage for long-term care, health care in rural America, and the role of the Peer Reveiw Organizations. I look forward to hearing the testimony and sharing in what should be a very interesting exchange.

Jay Rockefeller

OPENING STATEMENT
FINANCE HEALTH SUBCOMMITTEE HEARING ON HEALTH ISSUES
SENATOR JOHN D. ROCKEFELLER IV
January 29, 1987

Mr. Chairman, I truly look forward to working on your subcommittee. With you at the helm, we can be sure that this subcommittee will be the forum for a great deal of serious, thoughtful, and productive work in addressing health issues.

I share with you, Mr. Chairman, a number of concerns that stem from the common charateristics of our respective states. Like Maine, West Virginia is largely rural and has a significant low-income population. The nation's recent economic problems have hit West Virginia especially hard, throwing productive citizens out of work and leaving them with no or little health insurance. My state also has a disproportionately high number of elderly -- 15% of our population is 65 years and over in contrast to the 11% or so nationwide.

I hear from constituents (seniors especially), health providers, and social service directors constantly about the problems they are encountering in health care. As a rural state, we have areas which don't have enough doctors. In fact, in southern West Virginia, pregnant women often travel long distances to receive the basic care they need -- if they receive it at all. Our rural hospitals report horrendous financial situations. Their potential loss in certain communities jeapordizes many of our citizens.

My state's health-related needs, I realize, can not be solved through Medicare and Medicaid alone, or even with the help only of the federal government. But I strongly believe we should pursue opportunities to improve and strengthen these two major programs to provide better and more accessible care to the poor and elderly.

I am here to listen and learn. I'm a new member of this subcommittee, and am anxious to begin working on the pressing issues within the Medicare and Medicaid systems. Today's hearing provides an important opportunity to find out how some of our nation's foremost experts in health policy define those issues and where they think our subcommittee should head.

MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS: AN OVERVIEW OF MAJOR LEGISLATION ENACTED FROM 1980 THROUGH 1986

Background Paper

Prepared for the Use of the Members of
the Committee on Fianance

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Education and Public Welfare Divsion

January 1987

MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS: AN OVERVIEW OF MAJOR LEGISLATION ENACTED FROM 1980 THROUGH 1986

I. INTRODUCTION

Since 1980, seven major laws have made significant amendments to the Medicare, Medicaid, and Maternal and Child Health programs under the jurisdiction of the Senate Finance Committee. Most of the changes were made within the context of budget reconciliation legislation which sought to reduce the rate of growth of Medicare outlays by reducing program expenditures or increasing program revenues or both. In the case of the Medicaid and Maternal and Child Health programs outlays were initially reduced and then increased in subsequent years.

In August 1983, the Congressional Budget Office (CBO) estimated that legislative changes enacted from January 1981 through July 1983, reduced Medicare outlays over what would otherwise have been expended over the FY 1982-FY 1985 period by $13.2 billion or 5 percent of program outlays. In January 1985, CBO estimated that Medicare program outlays have been reduced by $8.6 billion in FY 1986, $10.5 billion in FY 1987, and $12.5 billion in 1988. These numbers cannot be summed, however, since other factors, such as changing the effects of economic assumptions, are reflected in the estimates.

In August 1983, CBO estimated that legislative changes enacted from January 1981 through July 1983 reduced Medicaid outlays over what would otherwise have been expended over the FY 1982-FY 1985 period by $3.9 billion or

5 percent of program outlays. In August 1984, after the enactment of P.L. 98-369, CBO estimated that the law would increase Medicaid outlays by $159 million over the FY 1984-FY 1987 period. These numbers cannot be summed since other factors like changing economic assumptions are reflected in the estimates.

The major laws making these changes were:

-- P.L. 96-499, the Omnibus Reconcilation Act of 1980

-- P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981

-- P.L. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982

-- P.L. 98-21, the Social Security Amendments of 1983

-- P.L. 98-369, the Deficit Reduction Act of 1984

-- P.L. 99-272, the Consolidated Omnibus Reconciliation Act of 1985

-- P.L. 99-509, the Omnibus Reconciliation Act of 1986

The purpose of this report is to summarize the major amendments to these programs. It traces the major Medicare amendments which have affected hospitals, physicians, and beneficiaries since 1980. It reviews the major Medicaid amendments affecting Federal financial participation in the program, coverage of pregnant mothers and children, as well as those amendments designed to give States increased flexibility in administering their programs. Lastly, the report describes the consolidation of Federal health service programs for mothers and children under a new block grant authority.

These laws have made numerous important changes to Medicare and Medicaid, For reasons of space, not all of these changes could be included in this report. In the aggregate, however, the legislation reflects Congressional intent to reduce the rate of increase in outlays, protect vulnerable populations, encourage cost-effective services and benefits, and promote the provision of quality health care.

Table 1 summarizes estimated FY 1988 outlays for the Medicare, Medicaid and Maternal and Child Health Services Block Grant Programs.

TABLE 1. Medicare, Medicaid, and Maternal and Child Health Services Block Grant Estimated FY 1988 Program Outlays
(dollars in billions)

MEDICARE	
Part A Benefits	$51.5
Part B Benefits	33.1
Peer Review Organizations	0.2
Administrative Costs	1.8
Total	$86.6
MEDICAID	
Federal Share	$28.1
State Share	22.5
Total	$50.6
MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT	$ 0.478

SOURCE: U.S. Department of Health and Human Services. The Fiscal Year 1988 Budget and accompanying unpublished data.

II. MEDICARE

Medicare is a nationwide health insurance program for 32 million aged and disabled individuals. Medicare is composed of two parts. Part A, the Hospital Insurance Program, provides protection against hospital and related institutional costs. Part B, the Supplementary Medical Insurance program covers physicians services and a specified range of other medical services. Medicare outlays are estimated to reach $86.6 billion in FY 1988.

A. Hospitals

Before passage of P.L. 98-21, the Medicare program reimbursed hospitals for the reasonable costs they incurred in providing services to Medicare beneficiaries. Because the actual reasonable costs could not be determined until after the hospital had provided the services and reported its costs to the Medicare program, this method of reimbursement was known as "retrospective cost-based reimbursement."

Under authority provided by Section 222 of the Social Security Amendments of 1972 (P.L. 92-603), the Department of Health and Human Services (HHS) funded experiments and demonstration projects to evaluate the impact of making payments to hospitals on a "prospective" basis, which means fixed payment rates would be determined in advance of the provision of the hospital services.

Section 223 of the 1972 Amendments authorized the Secretary to set prospective limits on hospital costs that were recognized as reasonable by Medicare. Under this authority, HHS annually published limits on Medicare reimbursement to hospitals beginning in 1974. In addition, the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248, established a 3-year Medicare ceiling (or target rate) on the allowable annual rate of increase in operating costs per case for inpatient hospital services.

A provision in P.L. 97-248 required that HHS develop legislative proposals for the prospective reimbursement of hospitals (and other providers) by Medicare, to be reported to Congress by Dec. 31, 1982. Legislation based on the proposal in the HHS report was introduced in Congress, amended, approved, and signed into law on Apr. 20, 1983, as title VI of P.L. 98-21, the Social Security Amendments of 1983. The new method of Medicare payment for hospitals, called the prospective payment system (PPS), was effective for hospital cost reporting periods that began on or after Oct. 1, 1983. On Sept. 1, 1983, HHS issued an interim final rule in the Federal Register implementing title VI of P.L. 98-21; a final rule was issued Jan. 3, 1984.

Payment Methodology

Unless excluded from the prospective payment system, all Medicare participating hospitals are paid a specific amount for inpatient services provided to Medicare beneficiaries based on the patient's classification into one of 471 Diagnosis Related Groups (DRGs). Separate payment rates apply to hospitals located in urban or rural areas of the country as determined by OMB's Metropolitan Statistical Area system. Urban rates are higher than rural rates. Hospitals located in areas reclassified from urban to rural are allowed a 2-year transition to the rural rates. The DRG rates are adjusted by a wage index to account for local differences in hospital wage levels. P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985, requires that a new wage index developed by HHS, known as the HCFA gross wage index, be used after May 1, 1986.

Transition Period

The national DRG payment rates are phased in over a 4-year transition period. During the transition period, a hospital's payment rate is composed of a combination of Federal DRG payment rates and a hospital-specific rate. In addition, during the transition, the Federal portion of the DRG rate is based on a blend of national and regional payment amounts (the standardized payment amounts) for each of the nine census regions of the country. The hospital-specific rate is based on the hospital's historical costs per discharge updated to the current year. Both the Federal DRG rate and the hospital-specific rate are updated each year.

Thus, during the 1st year of the program (FY84), 75 percent of the prospective payment was based on the hospital specific portion and 25 percent was based on Federal DRG rates (100 percent regional). In year 2 (FY85), 50 percent of the payment was based on the hospital specific portion and 50 percent was based on Federal DRG rates (75 percent regional and 25 percent national). As provided in P.L. 99-201, the Emergency Extension Act of 1985, and P.L. 99-272, in year 3 (FY86) for the first 7 months of a hospital's cost reporting period, 50 percent of the payment was based on the hospital specific portion and 50 percent of on Federal DRG rates (75 percent regional and 25 percent national); during the remaining 5 months of a hospital's cost reporting period in FY86, 45 percent of the payment was based on the hospital specific portion and 55 percent on Federal DRG rates (75 percent regional and 25 percent national). In year 4 (FY87), 25 percent of the payment is based on the hospital specific portion and 75 percent on Federal DRG rates (50 percent regional and 50 percent national). In year 5 (FY88) and later years, the payment will be determined using 100 percent national Federal DRG rates.

DRG Payment Levels and Updating

The payment rates for each DRG are based on an average of historical (1981) Medicare cost data for each hospital. The rates were updated through FY83 by the estimated actual rate of increase in hospital costs nationally. The rates were increased for FY84 by the estimated annual increase in a marketbasket index representing the cost of goods and services purchased by hospitals, plus one percentage point. P.L. 98-369, the Deficit Reduction Act of 1984, provided that for FY85, the rate of increase would be the increase in the marketbasket plus one-quarter of a percentage point. For FY84 and FY85, the DRG rates were adjusted so that the total payments under the prospective system equal the payments which would have been made under the reasonable cost reimbursement provisions of prior law subject to the reasonable cost limits provided for in P.L. 97-248. This requirement is known as "budget neutrality."

For FY86, P.L. 99-201 and P.L. 99-272 provided that the FY86 PPS payment rates would be frozen at FY85 levels until May 1, 1986, and would be increased 1/2 percent for the remainder of the year. Under the mandatory sequestration provisions of P.L. 99-177 (the Balanced Budget and Emergency Deficit Control Act of 1985, known as Gramm-Rudman-Hollings) the FY86 Medicare payments to hospitals were reduced by 1 percent beginning March 1, 1986.

For FY87 and FY88, P.L. 99-272 provided that the Secretary could determine the updating factor for the PPS payment rates, not to exceed the marketbasket index change. However, P.L. 99-509, the Omnibus Budget Reconciliation Act of 1986, overrode the Secretary's determination that the PPS rates for FY87 would be increased by 0.5 percent, and provided that the rates would be increased by

1.15 percent in FY87 and by the hospital marketbasket minus 2 percent in FY88. The Administration's FY88 budget proposes to restore the discretion of the Secretary to set the update factor for FY 1988.

To determine the total payment to the hospital for a particular DRG, the blended amount (which includes both the hospital-specific and the Federal DRG portion) is multiplied by the relative weight for that particular DRG. Each of the 471 DRGs has been assigned its own weight. P.L. 98-21 required the HHS Secretary to adjust the DRG classification and weighting factors in FY86 and at least every 4 years thereafter to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources. P.L. 99-509, however, required the Secretary to adjust the DRG classification and weighting factors each year, beginning in FY88.

Outliers

Additional amounts are paid to hospitals for atypical cases (known as "outliers") which have either extremely long lengths of stay or extraordinarily high costs compared to most patients classified in the same DRG. The law requires that total outlier payments to all hospitals represent no less than 5 percent and no more than 6 percent of the total estimated Medicare prospective payments for the fiscal year. Outlier payments are financed by an offsetting overall reduction in the Federal portion of the DRG rates. P.L. 99-509 established a separate urban and a separate rural set-aside factor for financing the outlier payments.

Indirect Medical Education Costs

P.L. 98-21 provided that adjustments to the DRG payments are made to hospitals under PPS for the indirect costs attributable to approved medical education programs. These adjustments provided for an increase of 11.56 percent for each increase of 0.1 in a hospital's ratio of interns and residents to beds. P.L. 99-272, reduced the amount of the payment. The formula for determining the payment provides, from May 1, 1986 to Oct. 1, 1988 an increase of approximately 8.1 percent in the Federal portion of the DRG payment (increasing with the ratio of the hospital's number of interns and residents to its bed size), applied on a curvilinear or variable basis (i.e., the increase in the payment is less than proportional to the increase in the ratio of interns and residents to bed size). The payment adjustment after Oct. 1, 1988, would be an increase of approximately 8.7 percent. The Administration's FY 1988 budget proposal would reduce the factor to 4.05 percent calculated on the same curvilinear basis.

Disproportionate Share Hospitals

P.L. 99-272 provided that additional payments will be made from May 1, 1986, to Oct. 1, 1988, to hospitals that serve a disproportionate share of low-income Medicare and Medicaid patients. For urban PPS hospitals with more than 100 beds having a percentage of low-income patients of at least 15 percent, the Federal portion of the hospital's PPS payment would be increased by 2.5 percent plus one-half the difference between 15 percent and the hospital's percentage of low-income patients, not to exceed a 15 percent adjustment. For urban hospitals with less than 100 beds having a percentage of low-income patients of at least 40 percent, the payment increase would be 5 percent. For rural hospitals having a low-income patient percentage of at least 45 percent, the payment increase would be 4 percent.

Payments will also be made to urban hospitals with 100 or more beds which demonstrate that more than 30 percent of their revenues are derived from State and local government payments for indigent care (excluding payments under Medicare and Medicaid).

P.L. 99-509 authorized the Secretary to establish a separate threshold percentage of low-income patients required for rural hospitals of 500 or more beds to qualify for disproportionate share payments. The legislation also continued payment to disproportionate share hospitals through Oct. 1, 1989, in a budget neutral fashion (i.e., the Federal portion of DRG payment rates is reduced proportionally to finance the disproprotionate share payments).

Direct Medical Education Costs

The direct costs of approved medical education programs (such as the salaries of residents and teachers and other education costs for residents, nurses, and allied health professionals) are excluded from the prospective payment system and paid for on a reasonable cost basis.

P.L. 99-272 provided a formula for paying for the direct costs of approved graduate medical education programs. Such programs were to be paid on the basis of a hospital specific cost amount per approved full-time resident. The Secretary of HHS is not permitted, unless specifically authorized, to limit the rate of increase on allowable costs of approved medical education activities. The Administration's FY 1988 budget proposed to repeal the prohibition against further limits on direct medical education costs. It would also eliminate certain educational subsidies including classroom and other educational program costs, and payments for undergraduate nursing and allied health professional education.

Capital-Related Costs

Capital-related costs (including depreciation, leases and rentals, interest, and a return on equity for proprietary hosptials) are excluded from the prospective payment system until Oct. 1, 1987, and are paid for on a reasonable cost basis (i.e., the hospitals actual capital costs multiplied by Medicare's share of total capital costs attributable to in-patient services). P.L. 98-21 required the Secretary to report to Congress within 18 months of enactment on methods and proposals by which capital costs in the prospective payment rates. If Congress does not enact legislation by Oct. 1, 1987, to include capital-related costs under PPS, Medicare payment for capital costs will be prohibited after Sept. 30, 1987, unless a State has a capital expenditure review agreement with the Secretary (under Section 1122 of the Social Security Act) and the State has recommended approval of the specific capital expenditure.

The FY 1988 Administration Budget contains a regulatory proposal to gradually incorporate Medicare payment of hospital capital costs into PPS. This would be done on a budget neutral basis consistent with funding levels achieved under P.L. 99-509. Under the proposal a fixed PPS payment would be made encompassing both operating and capital costs. The capital payment amount would include a national portion based on Medicare capital costs and, during the transition period, a hospital specific portion based on current reimbursement policies. Both the national portion and the hospital specific portion of the capital payment amount would be separated between fixed plant and movable equipment costs. Payments for fixed plant would be phased into PPS over a 10-year transition period; payments for movable equipment would be phased into PPS over a 2-year transition period.

P.L. 99-272 provided that payments to proprietary hospitals for a return on equity (ROE) will be separated from payments for other capital costs and will be phased out as follows: for hosptial cost reporting periods beginning in FY87, payment will equal 75 percent of the otherwise allowable ROE amount; for FY88, 50 percent; for FY89, 25 percent; and for FY90 and therafter, no ROE payments will be made.

P.L. 99-509 reduced payment amounts for capital-related costs by 3.5 percent for portions of cost-reporting periods in FY87, 7 percent for FY88, and 10 percent for FY89. The legislation exempts sole community hospitals from capital-related payment reductions and regulations for 3 years. It also clarifies that the HHS Secretary may incorporate capital-related costs, on a budget neutral basis into PPS, effective Oct. 1, 1987.

The FY 1988 budget proposal would provide by regulation for the elimination of ROE payments to hospital outpatient departments.

Certain exceptions and adjustments to the prospective payment rates are provided for sole community hospitals, cancer hospitals and referral centers.

Sole Community Hospitals

The Secretary is required to apply a special payment for sole community hospitals (SCHs), which are hospitals that (by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals) are the sole source of inpatient services reasonably available in a geographic area. SCHs are paid on the same basis as all other hospitals are paid in the first year of the transition period: 25 percent of the payment is based on regional DRG rates and 75 percent on each hospital's cost base.

During the transition period, SCHs may also receive an additional payment amount if, due to circumstances beyond their control, they experience a decrease of more than 5 percent in their number of inpatient cases. P.L. 99-509 provided that this adjustment would be extended up to October 1, 1986.

For cost reporting periods beginning on or after October 1, 1983, and before October 1, 1989, P.L. 99-272 provided that SCHs experiencing increases in operating costs due to the addition of new inpatient facilities or services will receive a payment adjustment for such costs.

Cancer Hospitals

The Secretary is authorized to provide for exceptions and adjustments to the prospective payment amounts appropriate for hospitals involved extensively in treatment for and research on cancer. Regulations define a cancer hospital as one which: (1) was recognized by the National Cancer Institute as a comprehensive cancer center or a clinical cancer research center as of April 20, 1983, (2) demonstrates that the entire facility is organized primarily for treatment of and research on cancer, and (3) has a patient population such that at least 50 percent of the hospital's total discharges have a principal diagnosis that reflects a finding of neoplastic disease. Cancer hospitals meeting these criteria may elect to be paid on a reasonable cost basis.

Rural Referral Centers

The Secretary is authorized to provide exceptions and adjustments appropriate for regional and national referral centers located in rural areas. These centers are defined as:

(1) rural hospitals having 500 or more beds;

(2) hospitals having at least 50 percent of their Medicare patients referred from other hospitals or from physicians not on the hospital's staff, at least 60 percent of their Medicare patients residing more than 25 miles from the hospital, and at least 60 percent of the services furnished to Medicare beneficiaries are furnished to those who live 25 miles or more from the hospital; or

(3) rural hospitals meeting the following criteria for hospital cost reporting periods beginning on or after October 1, 1985:

(a) a case mix index equal to or greater than the median case mix for urban hospitals located in the same census region or the Nation (other than hospitals with approved teaching programs);

(b) a minimum number of discharges of either 5,000, the national discharge criterion (or 3,000 in the case of osteopathic hospitals), or the median number of discharges in urban hospitals for the region in which the hospital is located; and

(c) at least one of the following three criteria: more than 50 percent of the hospital's medical staff are specialists, at least 60 percent of discharges are for inpatients who reside more than 25 miles from the hospital, or at least 40 percent of inpatients treated at the hospital have been referred either from physicians not on the hospital's staff or from other hospitals.

Hospitals meeting these criteria will be paid prospectively based on the applicable urban payment rates rather than the rural rates, as adjusted by the hospital's area wage index. Under the regulations, once a hospital has achieved referral center status, it is paid at the applicable urban rate for a 3-year period. P.L. 99-509 permitted hospitals designated as regional referral centers, as of the date of enactment, to continue their designation for 3 additional years.

Hospitals Excluded from the Prospective Payment System

The following hospitals are by law excluded from the prospective payment system and are paid on the basis of reasonable costs, subject to the

P.L. 97-248 rate in increase limits:

-- psychiatric hospitals;

-- rehabilitation hospitals;

-- psychiatric or rehabilitation units which are distinct parts of a hospital;

-- alcohol and drug hospitals and such distinct units of hospitals, for costs reporting periods beginning before October 1, 1987;

-- children's hospitals (with patients averaging under 18 years of age);

-- long-term hospitals (with an average inpatient length of stay greater than 25 days); and

-- hospitals outside the 50 States and the District of Columbia. P.L. 99-509 provided that hospitals located in Puerto Rico will be included in PPS, effective with discharges occurring on or after October 1, 1987.

Hospitals reimbursed under Medicare-approved State cost control systems are also excluded from the prospective payment system. In addition, there are special cases where the prospective payment system is not applied, such as for emergency services provided to Medicare beneficiaries in hospitals not participating in Medicare, Veterans Administration hospital services provided to Medicare beneficiaries, and hospital services provided to Medicare beneficiaries who belong to health maintenance organizations or competitive medical plans (such organizations may choose to have the Secretary pay hospitals directly for such services or may negotiate their own rates with hospitals).

Periodic Interim Payments to Hospitals

Prior to the enactment of P.L. 99-509, hospitals and certain other institutional providers meeting certain requirements were able to receive Medicare periodic interim payments (PIP) every 2 weeks based on estimated annual costs; a settlement was made at the end of the year based on actual bills. P.L. 99-509 provided for the elimination of PIP for PPS hospitals, with certain exceptions, after certain prompt payment requirements are met. The excepted hospitals are those that receive a disproportionate share add-on payment of 5.1 percent or more and certain small rural hospitals. The FY 1988 budget proposal would eliminate PIP for disproportionate share hospitals.

B. Physicians

Payment for physicians' services is generally made on the basis of "reasonable" charges. The reasonable charge for a service cannot exceed the actual charge for the service, the customary charge for the service, or the prevailing charge for the service in the community, subject to certain limitations. Medicare pays 80 percent of the reasonable charge amount after the beneficiary has met the $75 deductible. The beneficiary is liable for 20 percent coinsurance charges. If the physician accepts "assignment" on a claim he or she agrees to accept Medicare's reasonable charge determination as payment in full; in return, Medicare pays the physician or other supplier directly. If the physician does not accept assignment, Medicare payments are made to the beneficiary who in turn pays the physician. The beneficiary is liable for the deductible and coinsurance plus any difference between Medicare's reasonable charge and physician's actual charge. Under P.L. 98-369, a physician may become a "participating physician," i.e., a physician who agrees to accept assignment on all claims. Incentives are included for physicians to participate.

Under Medicare, "reasonable charges" cannot exceed:

-- the physician's actual charge for the service;

-- the physician's customary charge for the service; and

-- the "prevailing charge" for similar services in the locality (set at a level no higher than is necessary to cover the 75th percentile of customary charges).

Recent legislation, beginning with the enactment of P.L. 98-369 in 1984, made significant modifications in the physician payment provisions of Medicare.

P.L. 98-369 froze physicians' fees under Medicare for the 15-month period, July 1, 1984, through September 30, 1985. Therefore, the annual updating of customary and prevailing charge screens (i.e., benchmarks against which individual charges are compared), otherwise slated for July 1, 1984, did not occur. Subsequent fee screen updates were slated to occur on October 1, of future years beginning in 1985. P.L. 98-369 established the concept of participating physicians and specified that the first participation period began October 1, 1984. Participating physicians were subject to the 15-month freeze. They were, however, permitted to increase their billed charges during the freeze period. The law included additional incentives for physicians who agreed to become participating physicians. These included the publication of directories identifying participating physicians and the maintenance by carriers of toll free lines to provide beneficiaries with names of participating physicians.

The law specified that nonparticipating physicians could not increase their billed charges during the 15-month freeze period over the amounts charged for the same services during the April 1, 1984, through June 30, 1984, period. P.L. 98-369 required the Secretary to monitor charges of nonparticipating physicians and specified penalties for those who failed to comply with the freeze.

The Temporary Emergency Extension Act of 1985 (P.L. 99-107), as amended, extended the fee freeze provisions through March 14, 1986.

P.L. 99-272 extended the existing payment provisions (i.e., the freeze) through April 1986. In April 1986, physicians were given an opportunity to change their participation status for the 8-month period beginning May 1, 1986. Future update and participation cycles were scheduled to begin on January 1 of each year beginning in 1987. Physicians covered under participation agreements on May 1, 1986, received updates in their customary and prevailing charges. The freeze was extended through December 31, 1986 for nonparticipating physicians. This legislation also provided that, beginning January 1, 1987, nonparticipating physicians would be subject to the prevailing charge limits applied to participating physicians during the preceding participation period.

P.L. 99-509 made a number of changes in the physician payment provisions, as follows:

-- Beginning in 1987, all participating and all nonparticipating physicians will receive an increase in their prevailing charge levels, above those in effect for the previous period equal to 3.2 percent. In 1988 and future years, prevailing charges would be increased by the percentage increase in the Medical Economic Index (MEI) The MEI is an economic index which reflects changes in operating expenses of physicians and in earnings levels.

-- The one percentage point increase over the MEI, which was allowed for participating physicians for the period beginning May 1, 1986, was built into the base for future calculations.

-- The Secretary cannot retrospectively revise the calculation of the MEI. The Secretary is required to conduct a study of the MEI to ensure that the index reflects economic changes in an appropriate and equitable manner.

-- Nonparticipating physicians are subject to a limit on their actual charges.

-- Where the actual charge for a nonassigned elective surgical procedure exceeds $500, the physician is required to disclose to the individual in writing, the estimated charge, the estimated approved charge, the excess of the physician's actual charge over the approved charge, and the applicable coinsurance amount.

The FY 1988 Budget proposes the following changes to physician payments:

-- Establish customary charges for new physicians at approximately 80 percent of the prevailing charge;

-- Provide reductions for: physicians charges that are overpriced compared with other procedures; charges that vary excessively from one location to another; and global surgical fees that do not reflect recent reductions in hospital lengths of stay; and

-- Place limits on prevailing charges for certain medical or surgical services (excluding visits or consultations) where there is a large disparity between the charges of a specialist and non-specialist.

Inherent Reasonableness

Medicare has permitted the Secretary certain flexibility in determining a physician's reasonable or approved charge. P.L. 99-272 required the Secretary to promulgate regulations which specify explicitly the criteria of "inherent reasonableness" which are to be used for determining Medicare payments to physicians. Implementing regulations were issued August 16, 1986.

P.L. 99-509 authorizes the Secretary under the "inherent reasonableness" authority, to establish a payment level for physician services based on criteria other than the actual, customary, and prevailing charge for the service. The law specifies criteria and procedures for adjusting payment levels. The Secretary is required to review, by October 1, 1987, the inherent reasonableness of payments for 10 of the most costly procedures paid for under Part B.

Cataract Surgery

Cataract surgery involves the removal (by various means) of the natural lens of the eye and replacement of the lens by a prosthetic (artificial) lens.

Prosthetic lenses include externally worn contact lenses, eyeglasses, and most commonly, artificial lenses that are surgically implanted in the patient's eye. Cataract extractions with an intraocular lens implant (IOL) currently account for 90 percent of all cataract surgeries.

P.L. 99-272 required the Secretary to provide for separate payment amount determinations for cataract eyeglasses and cataract contact lenses and for the professional services related to them. The Secretary is to apply inherent reasonableness guidelines in determining the reasonableness of charges for such eyeglasses and lenses.

P.L. 99-272 also denied Medicare payment for assistants-at-surgery in a cataract operation unless prior approval is obtained from the peer review organization (PRO) or Medicare carrier. Such assistants cannot bill Medicare or the beneficiary for services which do not receive prior approval; nor can the primary physician bill for such services. P.L. 99-272 further required the Secretary to report to Congress by January 1, 1987, recommendations and guidelines regarding other surgical procedures for which an assistant-at-surgery is not generally medically necessary.

P.L. 99-509 reduces by 10 percent the prevailing charges for cataract surgical procedures performed in 1987; in 1988, the prevailing charge is reduced by an additional 2 percent. In no case could the reduced prevailing charge level be lower than 75 percent of a national average prevailing charge.

The FY 1988 Budget Proposal would reduce prevailing charges for cataract surgery by an additional 13 percent in FY 1988.

Radiology, Anesthesiology and Pathology Services

P.L. 99-509 required the Secretary to study and report to Congress by July 31, 1987, on the design and implementation of a prospective payment system for payment under Part B for radiology, anesthesiology, and pathology services (RAP services) furnished to hospital inpatients.

The FY 1988 Budget proposes to change Medicare's current mechanism for paying for radiology, anesthesiology, and pathology (RAP) services provided to hospital inpatients. Medicare would pay an average rate per discharge for all RAP services associated with the diagnostic category.

C. Beneficiaries and Benefits

The vast majority of persons reaching age 65 are automatically entitled to protection under the Hospital Insurance Program (Part A). Those over 65 not automatically entitled may voluntarily obtain protection by paying monthly the full actuarial cost of such coverage (currently $226). Part A is financed principally through a special ~~hospital~~ insurance payroll tax levied on employees, employers, and self-employed. Employees and employers contribute equal amounts, i.e., both are taxed at the same percentage rate. During calendar year 1987, each will pay a tax of 1.45 percent on the first $43,800 of covered earnings. Self-employed persons will pay a tax of 2.9 percent on the first $43,800 of covered earnings.

During each benefit period (which begins when an insured person enters a hospital and ends when he or she has been out of a hospital or skilled nursing facility for 60 consecutive days), Hospital Insurance will pay for:

- -- Ninety days of inpatient hospital care subject to a deductible ($520 in 1987). A daily copayment ($130 in 1987) is required for the 61st day through 90th day. An additional lifetime reserve of 60 days (subject to a $260 daily copayment in 1987) may be drawn upon when an individual exceeds 90 days in a benefit period.
- -- Up to 100 days in a skilled nursing facility for persons in need of skilled nursing care and/or rehabilitation services on a daily basis. After the first 20 days, beneficiaries must pay a daily copayment charge of $65.

Hospital Insurance will also pay for:

- Limited home health services. No deductibles or coinsurance payments are required for such services.
- Hospice services for the terminally ill. A beneficiary may elect to receive services for two 90-day periods and one subsequent 30-day period during his lifetime. Beneficiaries making this election must choose to receive services through a hospice and give up most other Medicare benefits. This election is revokable. Coinsurance charges are applied for drugs.

Coverage under the Supplementary Medical Insurance (Part B) program is voluntary. Virtually all persons age 65 and older and all persons covered by Hospital Insurance may elect to enroll in Part B. Part B is financed jointly through monthly premium charges on enrollees ($17.90 in calendar 1987) and from general revenues of the Treasury. The premium amount is updated every January 1. For the 5-year period beginning January 1, 1984, enrollee premiums must equal 25 percent of the estimated cost of coverage for the aged. (The same premiums are paid by the disabled though per capita expenditures for this group are higher.) Federal general revenues finance benefit payments and administrative costs not financed through premiums.

Part B covers physicians' services (including surgery, consultation, and office and institutional visits) and a range of other health services including outpatient hospital services, physical therapy, diagnostic and x-ray services, and durable medical equipment.

Recent legislation made a number of changes to the way the Part A deductible as well as the Part B deductible and premium are calculated. In addition, the legislation firmly established the concept of Medicare as a secondary payor under certain specified circumstances (e.g., working aged).

Inpatient Hospital Deductible

Medicare's inpatient hospital deductible must, by law, be revised each January. Prior to 1987, the deductible was updated based on a formula which reflected the average cost of a day of hospital care. P.L. 99-509 set the inpatient hospital deductible at $520 for 1987. The percentage increase in future years would be equal to the percentage change that applies to the Medicare hospital propective payment rates (adjusted for changes in real case mix). This index will approximate the increase in the average cost of a hospital admission.

Part B Deductible

Prior to the enactment of P.L. 97-35, beneficiaries were required to incur $60 annually in expenses for most covered medical services before the program began making payments. In determining whether the individual had met the deductible, expenses incurred in the current calendar year plus those incurred in the previous 3 months of the preceding year were considered. P.L. 97-35 increased the Part B deductible from $60 to $75 and eliminated the beneficiary's ability to carryover incurred expenses from the previous year in order to satisfy the requirements for meeting the Part B deductible in the following calendar year.

Part B Premium

Under the original Medicare law, beneficiary premiums paid for 50 percent of the cost of part B with the remaining 50 percent financed by Federal general revenues. However, between 1974 and 1982 the percentage increase in the part B premium could not exceed the percentage increase in social security cash benefits payments. As a result, premiums financed only 24 percent of program costs in 1983. A temporary provision of law, first authorized in P.L. 97-248, set the beneficiary premiums at 25 percent of program costs for elderly enrollees through 1985. P.L. 98-369 as amended by P.L. 99-272 extended this provision through 1988.

The FY 1988 budget proposes to establish separate premiums for three categories of individuals as follows:

-- For current enrollees: 25 percent of program costs

-- For new enrollees: 35 percent

-- For third-party payors who buy Part B coverage (primarily State Medicaid programs): 50 percent

Medicare as a Secondary Payor

Prior to P.L. 96-499, Medicare was the primary payor for medical care except where a workman's compensation program was responsible for medical services. P.L. 96-499 made Medicare a secondary payor in cases where services could be paid for under an automobile or liability insurance policy or plan or under a no-fault insurance plan.

P.L. 97-35 made Medicare the secondary payor for individuals with end-stage renal disease if the individual was also covered by an employer group health plan. The law specified that Medicare would be the secondary payor for the first 12 months after an individual with renal disease became eligible for Medicare benefits.

P.L. 97-248, as amended by 98-369, and 99-272 extended this concept to the working aged by making Medicare payments secondary for services provided to older workers and their spouses over age 65 who elect to be covered under their employer group health insurance plans. The provisions apply to workers of employers having 20 or more employees. Under P.L. 99-509, this concept could be applied only to employers of 100 or more employees for disabled beneficiaries electing such coverage. The FY 1988 budget proposes to permit disabled workers of employers having 20 or more employees to elect to have primary coverage under their employer's group health plan.

Benefit Changes

Recent legislation has made a number of changes to Medicare's benefit package to permit services to be offered in a more appropriate and flexible manner, and to encourage care in less costly outpatient settings and to encourage certain preventive health services.

P.L. 96-499 expanded the range of benefits that could be provided on a less costly basis outside of a hospital. The 1980 law:

-- permitted rehabilitation benefits to be provided by comprehensive outpatient rehabilitation facilities;

-- encouraged physicians to provide surgery on an outpatient basis by recognizing 100 percent reimbursement of the reasonable charges (as opposed to the standard 80 percent) of a physician performing certain surgical procedures in an ambulatory surgical center, hospital outpatient department or, his or her office;

-- raised the limit on the dollar amount of outpatient physicial therapy services which could be covered under the program.

P.L. 97-248 made a number of major changes intended to provide more cost effective care under the program while at the same time expanding the range of providers who could offer care under the program. A new health maintenance organization (HMO) benefit was added under P.L. 97-248, to encourage Medicare enrollment in these entities. The law replaced the existing requirements for HMO participation with a new provision which authorized test alternatives for providing a range of preventive health services under the program.

Long-Term Care

Medicare does not provide support for long-term care services. Its coverage, focused primarily on acute care, offers limited skilled nursing facility (SNF) and home health care benefits which are intended to supplement hospital and surgical services during accompanying periods of recovery from actue illness. Recent legislation has focused on expanding the availability of skilled nursing care, primarily in rural areas with a shortage of nursing home beds, and on developing a prospective payment system for SNFs. P.L. 96-499 permitted certain small rural hospitals to use their beds interchangeably, on a "swing-basis," as acute or long-term care beds as needed.

Both P.L. 97-248 and P.L. 99-272 contained provisions requiring the Secretary of Health and Human Services to report to Congress on various aspects of prospective payment for SNF care under Medicare. The President's budget proposal for FY 1988 would provide additional funds for the development and testing of alternative payments systems for SNFs.

End-Stage Renal Disease

Medicare covers certain individuals, under age 65, who suffer from end-stage renal disease (ESRD). Benefits for qualified ESRD beneficiaries include all Part A and Part B benefits. P.L. 97-35 required the Secretary of HHS to establish dual, or separately calculated, prospective rates for hospital-based and for free standing facilities providing renal dialysis to Medicare patients. The rates were to be composite in nature, that is, they take into account the reimbursement contracts with HMOs and "competitive medical plans" (CMPs) on a risk sharing (prospective) basis. Under a risk contract, an HMO or CMP agrees to provide beneficiaries with, at a minimum, Medicare's scope of benefits. Medicare pays the HMOs and CMPs a monthly capitation fee (premium) that is adjusted to reflect certain factors related to the characteristics of each plan's Medicare enrollees. The premium is set at 95 percent of the estimated value of the benefits the beneficiaries would have used had they remained in traditional Medicare. HMO and CMP provisions were amended in 1984 and 1986 by P.L. 98-369, 99-272, and 99-509.

The FY 1988 budget proposal would to expand this type of arrangement to organizations other than HMOs and CMPs; specifically, the budget proposes to permit Medicare to contract with private employers that currently provide health benefits to their retirees and, on a demonstration basis, to so-called preferred provider organizations.

P.L. 97-248 also authorized Part A coverage through September 1986 for hospice care services provided to terminally ill Medicare beneficiaries with a life expectancy of 6 months or less. Prior to that time Medicare had not covered hospice care, although certain hospice-type services were reimburseable. P.L. 99-272 made the hospice benefit permanent.

Although, in general, Medicare does not pay for preventive health services, two amendments to the program since 1980 have encouraged beneficiaries to seek such care, if the service is necessary for the prevention of illness. P.L. 96-611, Social Security Act Amendments, authorized coverage for pneumococcal vaccines. P.L. 98-369 covered hepatitis B vaccine for individuals at high or intermediate risk of contracting the disease. P.L. 99-272 authorized a 4-year demonstration program for Medicare beneficiaries to proportions of hospital-based and independent facility patients dialyzing at home and the relative costs of providing dialysis at home and in the facility. P.L. 99-509 requires the Secretary to reduce composite rates by $2 (rather than an estimated $5 announced by HHS) for services furnished after Oct. 1, 1986. An additional $0.50 would be subtracted from the rates for funding of the ESRD networks. The Secretary is prohibited from revising the composite rates for 2 years.

Peer Review

P.L. 97-248 established a Utilization and Quality Control Peer Review Organization Program to replace the existing Professional Standards Review Program. The legislation required the Secretary of HHS to enter into performance-based contracts with physician-sponsored or physician access organizatons known as Peer Review Organizations (PROs). P.L. 98-21, as amended by P.L. 98-369, required hospitals to have agreements with PROs by November 15, 1984, as a condition for receiving Medicare payments under the new prospective payment system.

PROs are charged with reviewing the services provided to Medicare patients to assure that services are medically necessary, provided in the appropriate setting, and meet professionally recognized standards of health care. PROs are expected both to focus on curtailing unnecessary costs and assuring the quality of health care. P.L. 99-272, as amended by P.L. 99-509, strengthened the ability of PROs to address issues of quality of care.

III. MEDICAID

Medicaid, authorized under title XIX of the Social Security Act, is a Federal-State matching program providing medical assistance for low-income persons who are aged, blind, disabled, or members of families with dependent children. Within Federal guidelines, each State designs and administers its own program. Thus, there is a substantial variation among the States in terms of persons covered, types and scope of benefits covered, and amounts of payments for services. Medicaid legislation in recent years has sought to control rising program costs, expand coverage of pregnant women and children, and permit States flexibility in administering their programs and providing more efficient services. Federal Medicaid outlays are estimated to total $28.1 billion in FY 1988. The State share in FY 1988 is estimated to be $22.4 billion.

A. Federal Financial Participation

The Federal Government helps States share in the cost of Medicaid services by means of a variable matching formula which is periodically adjusted. The matching rate can range from 50 percent to 83 percent, though currently the highest rate is 78 percent.

Reductions and Target Amounts

P.L. 97-35 provided that the amount of Federal matching payments to which a State was otherwise entitled was to be reduced by 3 percent in fiscal year 1982, 4 percent in fiscal year 1983, and 4.5 percent in fiscal year 1984. A State could lower the amount of its reduction by 1 percentage point for each of the following: (1) operating a qualified hospital cost review program; (2) sustaining an unemployment rate exceeding 150 percent of the national average; and (3) demonstrating recoveries from fraud and abuse activities (and with respect to fiscal year 1982, third-party recoveries) equal to 1 percent of Federal payments. A State was entitled to a dollar-for-dollar offset in its reductions if total Federal Medicaid expenditures in a year fell below a specified target amount. In no case could the amount recovered exceed the total amount of reductions.

The FY 1988 budget proposes to limit Federal Medicaid expenditures for medical assistance payments to $25.4 billion. The proposed limitation is $1.3 billion below the current services estimate of $26.7 billion. Within the overall spending limit, a State would receive in FY88 the same proportional share of funds that it expended in FY86. Federal payments to States would continue to match State expenditures but only up to each State's individual growth limit. Federal spending increases in future years would be limited to inflationary adjustments as measured by the medical care component of the consumer price index (CPI).

The FY 1988 budget also proposes the establishment of a one-time $300 million contingency fund or hardship funding pool in FY88. This fund, which is intended to ease the transition to the new Federal limit is to be used to assist States which, despite aggressive cost control efforts, have unusual cost increases.

Federal Matching Percentages

The Federal matching percentages, used to determine the Medicaid matching rate, are based on the average per capita income of each State and the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. Prior to P.L. 99-272, the Federal percentage was calculated biennially. The 1985 Act required an annual calculation of the Federal percentage.

Special Matching Rates

Current law specifies a Federal matching rate of 50 percent for administrative costs with the following exceptions: professional medical personnel used in program administration (75 percent); automated claims processing systems (90 percent for development, 75 percent for operation); establishment and operation of State fraud and abuse control units (90 percent for the first 3 years, 75 percent thereafter); and review activities conducted by peer review organizations under contracts (75 percent). The law also specifies a 90 percent matching rate for family planning services.

The FY 1988 budget proposes to eliminate special matching rates for administrative costs. Administrative costs would be matched at the regular 50 percent rate. The budget also proposes to reduce the matching rate for States with per recipient administrative expenditures over 135 percent of the national median. For costs between 135 percent and 160 percent of the national median, the matching rate would be 25 percent (rather than 50 percent). For costs above 160 percent of the median, no Federal matching funds would be provided. The FY 1988 budget also proposes to eliminate the special 90 percent matching rate for family planning services.

B. Eligibility

Eligibility for Medicaid is linked to actual or potential receipt of cash assistance under the federally assisted Aid to Families with Dependent Children (AFDC) program and the Federal Supplemental Security Income (SSI) program for the aged, blind, and disabled. All States cover the "categorically needy" under their Medicaid programs. In general, categorically needy are persons receiving cash assistance under AFDC or SSI. States have the option of limiting Medicaid coverage of SSI recipients by requiring them to meet any more restrictive eligibility standard that was in effect on January 1, 1972 (before implementation of SSI). States choosing the more restrictive criteria must allow applicants to deduct medical expenses from income in determining eligibility. States may also cover additional persons as categorically needy. For example, these might include persons who would be eligible for cash assistance, except that they are residents in medical institutions (such as skilled nursing facilities) or children up to age 21 (or reasonable classifications of these children) not meeting the AFDC definition of dependent children.

P.L. 98-369, as amended by P.L. 99-272, required States to extend categorically needy protection to the following groups of persons meeting AFDC income and resources requirements:

-- First-time pregnant women from medical verification of pregnancy (where such women would be eligible if the child were born);

-- Pregnant women in two-parent families where the principal bread-winner is unemployed;

-- Children born on or after October 1, 1983, up to age 5 in two-parent families; and

-- Effective July 1, 1986, pregnant women in two-parent families.

States may also cover the "medically needy" under their Medicaid programs. These are persons whose income is slightly in excess of the standards for cash assistance, provided that:

-- They are aged, blind, disabled, or members of families with dependent children; and

-- Their income (after deducting incurred medical expenses) falls below the State's medically needy standard (which may not exceed 133 1/3 percent of the State's AFDC standard for the same family size).

P.L. 99-509 gives States the option of extending Medicaid coverage to additional target groups with incomes between the existing State eligibility standard and a State-defined level below the Federal poverty line. The first target group (which States may begin covering April 1, 1987) is pregnant women and infants; beginning in FY88, coverage may be extended on an incremental basis to children under age 5. The second target group (which States may begin covering July 1, 1987) is elderly and disabled persons. For this second target group, States may provide full Medicaid coverage or, alternatively, just cover Medicare cost-sharing expenses. .

C. Waivers

Program recipients generally are able to obtain services from any provider or practitioner willing to provide them services (the "freedom-of-choice" requirement). P.L. 97-35 authorized waivers from this requirement. Under an approved waiver, States, as a cost-control device, are able to restrict a recipient's freedom-of-choice for non-emergency care provided certain conditions relating to access and quality are met.

P.L. 99-35 also authorized waivers for the provision of a broad range of home and community-based services (not including room and board) for individuals who would otherwise require care in skilled nursing or intermediate care facilities. These are frequently referred to as 2176 waivers after the comparable section in P.L. 97-35. Services authorized to be provided under a waiver include both those not available under the individual State's Medicaid plan and those not generally available under Medicaid because they are primarily non-medical in nature.

The FY 1988 budget would provide for waivers and demonstration projects to provide comprehensive case management services to pregnant women, including those who are at high risk of having low birth weight children and teenage pregnancies. Projects would be coordinated with the delivery of services through other Federal programs, namely Community Health Centers (CHCs), the Maternal and Child Health (MCH) block grant, and the Women, Infants, and Children (WIC) program.

No new Federal funds would be available for this initiative; funding would come from the savings attributable to eliminating the special matching rate for family planning services. The program would be funded through the Medicaid program; however, it has not yet been determined whether State matching for these services would be required.

IV. MATERNAL AND CHILD HEALTH BLOCK GRANT

In 1935, Congress authorized a program of formula grants to States to provide health services to mothers and children--title V of the Social Security Act, Maternal and Child Health (MCH), and Crippled Children's (CC) Services. Program funds were targeted primarily to mothers and children in rural or economically depressed areas. States were required to match a certain portion of the Federal allotment with their own funds.

P.L. 97-35 established a new Maternal and Child Health Services Block Grant under title V of the Social Security Act which consolidated a variety of statutory authorities for maternal and child health services under the Social Security and Public Health Service Acts. The new block replaced then-existing authorities for maternal and child health services and crippled children's services under title V, supplemental security income for disable children under title XVI of the Social Security Act, and Public Health Service Act programs for lead-based paint poisoning prevention, genetic diseases, sudden infant death syndrome, hemophilia, and adolescent pregnancy. Under the block's matching requirements, States must spend 75 cents to receive a dollar. The permanent authorization for the block was set at $373 million. The Secretary of HHS was authorized to set aside 15 percent of the block's appropriation in FY 1982 and between 10 and 15 percent of its appropriation in succeeding fiscal years for special projects of regional and national significance.

P.L. 98-369 raised the permanent authorization of the block to $478 million and changed the term "crippled children" to "children with special health care needs." P.L. 99-509 increased the authorization to $553 million for FY 1987, $557 million for FY 1988, and $561 in succeeding fiscal years. The law further required that a designated percentage of the newly authorized and appropirated amount was to be set-aside for projects for screening of newborns for sickle cell anemia and other genetic disorders (7 percent in FY 1987; 8 percent in FY 1988; and 9 percent in FY 1989). Of remaining new amounts, one-third must be used for primary and special needs health care services and projects for children. The FY 1988 budget proposes to fund the block grant at $478 million, the amount of its FY 1987 appropriation.

Senator MITCHELL. Good morning, ladies and gentlemen. I thank the witnesses for being here and I look forward to hearing your testimony at this morning's hearing, the purpose of which is to examine how the Medicare and Medicaid programs have been affected by deficit reduction efforts and structural changes since 1980.

We want to determine whether there have been any adverse effects on quality of care or access to care as a result of changes in these programs.

We will also look at the Administration's proposed budget to examine where reductions have been recommended in the Medicare and Medicaid programs, who will be affected by those reductions, and whether quality of care or access to care may be jeopardized by them.

We will at the same time search on our own for program areas where further cuts can be made without jeopardizing the health care of the nation's elderly and poor or placing an unfair burden on providers.

We must exercise restraint in all spending programs in this difficult budget period, including Medicare and Medicaid. At the same time, we seek to assure that all Americans, regardless of income level, age, or geographic location, have access to quality health care. Americans will not and should not be forced to accept a two-tier system of health care based upon income.

It is difficult to determine the exact amount of savings in the Medicare program which have been achieved during the last six years. We do know that in August of 1983 the CBO estimated that legislative changes enacted between January 1981 and through July 1983 reduced Medicare outlays by over $13 billion below expected expenditures in the 3-year period from fiscal year 1982 to 1985. That was about 5 percent of program outlays.

In August of 1984, the CBO estimated that Medical program outlays achieved in the Deficit Reduction Act of 1984 would total $6.1 billion over the then forthcoming 3-year period. While these amounts are difficult to establish precisely because of other related factors, such as the changing effects of economic assumptions, we do know that the cost of the programs has been reduced over expected outlays. These savings reduced the deficit, hold down the rising cost of the Medicare program and of health care cost in general.

We must, however, always be mindful of the human cost and loss of services to Medicare beneficiaries.

Since the implementation of the prospective payment system in 1983, there has been a significant decline in inpatient days and an increase in outpatient surgery with several procedures. These changes are a major reason for the savings in the Medicare program. They are also a cause of concern by many elderly citizens regarding the quality of care.

The prospective payment system does not take into account so-called social factors, such as distance from a hospital, weather, or whether the patient has someone at home capable of caring for him upon return from the hospital.

At the same time, Medicare beneficiaries are allegedly being discharged from hospitals earlier and sicker, and the denial rate for home health benefits under the Medicare program are increasing. This could jeopardize the health care of the elderly.

Many of us on this subcommittee represent rural Americans. During the last Congress witnesses before this subcommittee testified about what they alleged to be the unfair reimbursement mechanism under the prospective payment system which provides urban hospitals a higher rate than rural hospitals, even though rural hospitals often have to compete with urban areas for professional staff and have higher transportation cost with supplies and equipment.

Health care in rural America is further jeopardized by the sometimes inadequate supply of physicians in some remote areas and the often inadequate reimbursement to family practitioners who are the backbone of health care in rural America.

Under the Medicare program, family practitioners are reimbursed at lower rates than specialists.

When this committee examines the graduate medical education program under Medicare, we must keep in mind the need for physicians, particularly family practitioners, in rural America.

Since quality of care is a major concern to this committee, we should closely examine—and we will closely examine—the primary Medicare program which was intended to monitor quality of care, the peer review program.

The PRO was intended by Congress to act primarily as a check of quality of hospital care for Medicare beneficiaries. Its additional goal was to contain cost to the program to assure that beneficiaries were not overutilizing services. Unfortunately, as implemented, the PRO program has not complied with the intent of Congress in assuring quality of care in hospitals for Medicare beneficiaries.

The PRO program has become solely a cost containment mechanism, totally budget driven. This is not acceptable to me, nor to other members of this subcommittee.

I believe in the peer review concept. It is important to have professional review to make sure that the elderly are being cared for in an appropriate manner, and that the program is not paying for unnecessary services. But both objectives have to be met.

We will also examine the Medicaid program today. That is a costly program but a necessary one which provides basic health care to the nation's poor, including persons of all ages. Since this is a federal-state match, it is important that each of us in Congress be in close contact with the program's administrators in our home states.

The Administration has again proposed a cap on the Medicaid program. Congress has rejected this proposal in the past. While Medicaid provides funding for health care in a variety of ways, its contribution to long-term care cost for the elderly are, of course, enormous. In most states, Medicaid pays the lion's share of nursing home cost for many elderly persons who cannot afford the higher expense of skilled or intermediate care.

Long-term care for the elderly is a major crisis in this country. We must examine the existing reimbursement mechanisms for long-term care, both institutional and home health, and find viable ways to provide long-term care for the elderly in an effort to take some of the burden off the Medicaid program. Medicaid was not intended to provide health care for middle income Americans. Yet, many middle income Americans find themselves with inadequate funds to finance the huge cost of long-term stay in a nursing home.

I hope that some of the witnesses here today will be able to address the issue of Medicaid cost for long-term care and make recommendations to us on that issue.

I welcome all of the members of the subcommittee, those here and those who are coming, and I look forward to working with them. I want to say that for the past several years it has been my pleasure to serve on this subcommittee under the excellent leadership of Senator Durenberger. I am pleased that he will be the ranking member of the subcommittee. And I hope that we can conduct the affairs of this subcommittee in the same fair and non-partisan caring manner in which he has conducted it in the previous years.

And, Senator Durenberger, I welcome you here. Senator Rockefeller, although we have the early bird rule, I wonder, Senator, if you would object if you would object to my yielding to Senator Durenberger, the ranking member and former chairman of the committee, first.

Senator ROCKEFELLER. Certainly, Mr. Chairman.

Senator MITCHELL. Thank you. Senator Durenberger.

Senator DURENBERGER. Thank you very much, Mr. Chairman. I don't have a prepared statement. I just asked Helen to go get a photographer so we can get this particular group all in one place. It is of rare talent. Rhinehart did not bring his projector with him. Thank God. He throws slides all over the place. We would have to pay $5,000 for the privilege of having him throw them on the wall. [Laughter.]

But I say to the chair of the committee that I have been grateful over the years for your work, George, and all of the members of the subcommittee. And probably in the Finance Committee. It has been a subcommittee that has worked harder and longer than any other subcommittee certainly. And the last couple of years the issues we have dealt with have been full committee issues, and they are going to be again this year, which puts a strain on your leadership in this area. But I know you are more than capable and you are certainly starting out in the right way because these are all the people that I have used in my past tenure as the chair on this subcommittee, and more, you will find them extremely valuable. You will find for each of them a difficulty in limiting themselves to five minutes, but they are capable of it. Nobody will interpret what they know on the basis of what they say here today because there just isn't enough time to explore all of the issues. But what you are doing, laying the groundwork, getting a view of the past, these people are the most appropriate ones to begin with.

Senator MITCHELL. Thank you, Senator Durenberger.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I have an opening statement which I ask to be included in the record.

I might start by pointing out to the panel members that I am a new member of this subcommittee. This is our first meeting of the year, and I cannot think of a more distinguished panel to join us as we begin our deliberations.

I come, as does the chairman, from a very rural state. In fact, I believe that our states are the two most rural in the nation. Mine is a very poor one, West Virginia, and every imaginable sort of health care problem exists there. For example, we have a lot of unemployed coal miners in the southern part of West Virginia who lack health insurance and have difficulty getting medical care. There is a shortage of doctors in most parts of West Virginia. We train doctors and they go elsewhere.

We have a large elderly population—15 percent of our state's population—as opposed to 11 percent nationally; hospitals which are on the brink of closing, hospitals which have closed, hospitals which aren't sure how to reduce their costs. These are state efforts to try to do something about this, but they are only getting modest results.

I am very glad to be on the subcommittee. And I am extremely honored to have nine people such as yourselves to listen to and learn from. I thank the chairman.

Senator **Mitchell**. Thank you, Senator Rockefeller.

Senator Chafee?

Senator **Chafee**. I have no questions, Mr. Chairman.

Senator **Mitchell**. Thank you.

Now we have an unusually large panel this morning. We have done this deliberately in the hopes of encouraging exchange among the witnesses as well as between the witnesses and the members of the subcommittee.

I would like to ask each of the witnesses to stay within the 5-minute rule for oral statements. And I will tell you at the outset that the rule will be enforced. When the red light comes on you can finish the sentence you are in the middle of, but then wrap it up because otherwise it is unfair to the other witnesses.

As you know, your full statement will be inserted in the record. So your oral testimony should be a summary and a highlight of those points that you feel are most significant.

We will begin with Mr. Zimmerman, of the General Accounting Office, and then we will proceed to take the other witnesses in alphabetical order.

Mr. Zimmerman, welcome, and we look forward to your testimony.

STATEMENT OF MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. **Zimmerman**. Thank you, Mr. Chairman.

I am pleased to be here today as a member of this panel to discuss budgetary issues relating to Medicare and Medicaid.

Since the beginning of these programs, GAO has worked extensively with this committee and other Senate and House committees to devise legislative changes to these programs that will contain cost while attempting to prevent adverse effects on program beneficiaries.

During the last six years, many changes have been made to these programs in an effort to control their cost growth, with some degree of success.

You asked us to comment on areas where we believe additional changes could be made to further reduce Medicare and Medicaid costs or to enhance the program in areas that may have already been cut too severely. You also asked for areas where administration of the programs can be improved to save money or better serve the public.

My statement addresses nine areas that we believe are worthy of consideration. Rather than saying a few words about each, I will use my remaining time to discuss three of them.

The first issue I will discuss is capitation. The Administration will propose initiatives to expand the use of HMO, CMPs and similar capitated plans by both programs. The concept behind HMOs and CMPs is good: pay a fixed amount for beneficiaries for all covered services. The plan assumes a risk which, in turn, provides incentives to hold down costs. If the plan succeeds in keeping costs down, it realizes a profit.

GAO has issued a number of reports since 1974 on Medicare-Medicaid use of capitated health plans. The three general thrusts of those reports have been problems with setting payment rates, inadequate mechanisms to assure quality of care, and administrative problems such as controlling enrollment and disenrollment of beneficiaries.

Our latest work in this area in Florida and Arizona shows that these problems continue. Last year, the Congress took action to strengthen quality of care controls and alleviated administrative problems. We also recommended that HHS take a number of actions, including improving its rate setting methodology for Medicare. We believe that it would be prudent to see if the changes that have been made are effective before launching major new efforts to expand the use of capitated plans by the programs.

The next issue I would like to discuss is catastrophic health insurance for the elderly.

We believe that the information presented in our October 1986 report on Medigap insurance will be useful to the Congress in deciding whether catastrophic protection for Medicare covered services should be added to the Medicare program or whether the private sector should be encouraged to provide such protection.

We found that Medigap insurance policies sold by commercial insurers in 1984 returned only 60 cents of every dollar in earned premiums to policy holders as benefits. For the 13 Blue Cross and Blue Shield plans included in our review, the average was 81 cents. In contrast, Medicare pays about 97 percent of its cost as benefits. Thus, it appears, in 1984, the private sector spent as much to administer the $5 billion Medigap market as the government paid the carriers and intermediaries to administer the $65 billion Medicare program.

The final issue I will present is third-party liability. Since 1980, the Congress has enacted a series of provisions expanding the types of insurance that are primary to Medicare and has directed HHS to improve Medicaid third-party liability programs as we recommended. Both programs have realized large savings from these actions. Additional Medicare savings are available from better administration of its secondary payor program.

I have with me copies of a report we are issuing to the Finance Committee's ranking minority member. This report recommends several actions to increase third-party liability savings on hospitals. Implementation of those recommendations should save hundreds of millions of dollars for Medicare.

We will also be looking at the administration of Medicare's secondary payor program for Part B to see if savings can be increased there.

That concludes my opening remarks, Mr. Chairman.

Senator MITCHELL. Thank you very much, Mr. Zimmerman.

[The prepared written statement of Mr. Zimmerman follows:]

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MEDICARE AND MEDICAID

BUDGET ISSUES

Statement of
Michael Zimmerman, Senior
Associate Director
Human Resources Division

Before the
Subcommittee on Health
Senate Committee on Finance

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the views of the General Accounting Office about issues related to the budget for Medicare and Medicaid. Since the beginning of these programs, we have worked extensively with this Committee, and other Senate and House Committees, to devise legislative changes to these programs that would contain costs while attempting to prevent adverse effects on program beneficiaries.

During the last 6 years, many changes have been made to these programs in an effort to control their cost growth. Today I would like to summarize what has happened as a result of these changes and comment on some areas where additional changes could be warranted.

MEDICARE AND MEDICAID CHANGES FOR FISCAL YEARS 1981-87

Since 1980, the Congress has enacted at least 34 pieces of legislation that have affected Medicare and Medicaid. While these laws included some benefit expansion and revenue increase provisions, the primary thrust has been cost containment. The most significant acts over this period have been the six reconciliation bills enacted from 1980 through 1986. The Congressional Budget Office estimated that the first five reconciliation acts would result in a net reduction of about

$22 billion in Medicare expenditures through fiscal year 1986 and a reduction of about $3.8 billion in federal Medicaid expenditures during the same period. Some of the major changes resulting in reduced federal costs have been:

-- Requiring liability insurance and employer-sponsored health insurance to be the primary payor for Medicare beneficiaries covered by such insurance.

-- Limiting federal sharing in state Medicaid costs during fiscal years 1982-84.

-- Establishing ceilings in 1982 for Medicare payments of hospital operating costs. The savings from this provision were carried over to Medicare's prospective payment system (PPS) through its "budget neutrality" provision.

-- Freezing Medicare payment rates for physician services from July 1984 through December 1986.

-- Increasing Medicare Part B beneficiary costs by raising the deductible from $60 to $75 and requiring higher premiums.

Overall, most of the anticipated savings came from controlling payments to providers of health services (primarily hospitals) and requiring other insurers (and thus employers through higher premiums) to pay. But significant federal cost reductions also came from increasing Medicare beneficiary costs.

There also were two provisions that resulted in substantial increases in revenues from payroll taxes for part A of Medicare

-- Coverage of federal employees.

-- Coverage of state and local government employees hired after April 1, 1986.

The Department of Health and Human Services (HHS) also made a number of regulatory changes to Medicare and Medicaid in the last 6 years. However, the savings from those changes were probably small in comparison to savings resulting from the changes enacted by the Congress.

AREAS WHERE FURTHER CHANGE MAY BE WARRANTED

You asked us to comment on areas where we believe additional changes could be made either (1) to further reduce Medicare and Medicaid costs or (2) to enhance the programs in areas that may have been cut too severely. You also asked for areas where administration of the programs can be improved to save money or better serve the public. I will primarily address the first issue. We have done and are currently doing extensive work related to controlling costs. Our ongoing and past work related to areas that may have been cut too much has not yielded firm conclusions to date because of a lack of data necessary to address such questions as the effect of program changes on the quality of and access to care.

Rebasing PPS Rates

The first issue I would like to address is the need to rebase PPS; that is, recompute the payment factor for PPS on the basis of recent, audited cost data. Currently, this payment factor is about $3,000 for urban hospitals, which means that on average Medicare pays these hospitals this amount for all the operating costs associated with a discharge of a Medicare patient. This amount is based on the average Medicare payment in 1981 with numerous adjustments that were supposed to account for changes since then.

We have issued a series of reports on problems with the data bases used to compute PPS payment rates.[1] We reported on

- -- inflation of PPS rates because unaudited cost data were used to compute them;
- -- overstatement of rates because unreasonably high costs, which might not be eliminated even if the cost data were audited, were included in cost data; and
- -- PPS rates being higher because the costs of services that were not medically necessary were included in the data bases.

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[1] Need to Eliminate Payments for Unnecessary Hospital Ancillary Services, GAO/HRD-83-74, September 30, 1983; Excessive Respiratory Therapy Cost and Utilization Data Used in Setting Medicare's Prospective Payment Rates, GAO/HRD-84-90, September 28, 1984; Medicare's Policies and Prospective Payment Rates for Cardiac Pacemaker Surgeries Need Review and Revision, GAO/HRD-85-39, February 26, 1985; Use of Unaudited Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates, GAO/HRD-85-74, July 18, 1985; Additional Changes to the Medicare Reimbursement Rates for Major Joint Procedures Are Needed, GAO-85-109, September 12, 1985; Medicare: Past Overuse of Intensive Care Services Inflates Hospital Payments, GAO/HRD-86-25, March 7, 1986.

PPS gave hospitals incentives to eliminate unreasonably high costs and unnecessary services, and we believe that hospitals have reacted to these incentives. And we see no reason why payments should be based on unaudited costs that historically have included 3-percent unallowable costs. We have recommended that HHS rebase PPS using recent, audited cost data so that PPS rates would be based on reasonable cost data reflecting the changes that have occurred under PPS. HHS has not responded favorably to this recommendation. It indicated that it may lack authority to rebase although we pointed out how HHS could in effect rebase under current law.

Because of the numerous adjustments that HHS and the Congress have made to PPS payment rates over the years, we cannot be certain that savings would result from rebasing. However, given the magnitude of the problems with the data bases, we believe that it is reasonable to expect some savings. On the other hand, if rebasing would result in increased payments, this would address the Committee's concerns that cuts in some areas may have been too severe. In effect, if increased payments resulted from rebasing, it would indicate that PPS rates are inadequate.

In either case, we believe it is time to rebase PPS so that there is some assurance that payment rates reflect the costs hospitals must incur to efficiently provide medically necessary care. This is the criterion established by law for PPS payments.

Cost-Reporting Requirements

An area closely related to that of rebasing PPS is the continued availability to the government of adequate data on hospital costs. Current law requires hospital cost reporting through 1987. We believe that hospitals should continue to report their costs in the future, and that Medicare should continue to audit those cost reports. While there are Medicare and hospital costs associated with cost reporting, we believe the benefits can be substantial.

Adequate cost data are necessary for rebasing. Accurate data are also important for determining the effect of new technology on hospital costs, for if Medicare payments are not appropriately adjusted to reflect changing technology, Medicare, as the largest payor of hospitals, could provide disincentives to adopting improved technology.

Finally, we expect that hospitals will continue to maintain internal cost reporting for their management purposes. Medicare as a payor should have an independent source of cost data so that the government does not have to rely on the hospital industry as the sole source of such data. Audited cost reports would serve this purpose.

Paying for Hospital Capital Costs

Another area related to Medicare hospital payments is how to pay for capital costs. From Medicare's inception, hospitals were paid their actual reasonable capital costs. When the Congress enacted PPS, it directed HHS to study and recommend whether capital should be included in the prospective rates. In 1986, HHS proposed that all capital costs be paid prospectively with a 4-year transition program. The Congress precluded HHS from administratively finalizing this proposal and instead required that capital payments be reduced by 3, 7, and 10 percent in fiscal years 1987, 1988, and 1989, respectively.

In August 1986,2, we issued a report analyzing HHS's prospective capital proposal and the proposals of a number of other organizations and individuals. Because of hospitals' relative inability to adjust their capital costs in response to prospective payments and because of the potential adverse effects of prospective capital payments on the ability of hospitals to raise capital funds, we proposed three alternatives to HHS's prospective capital payment plan. They were

-- using a long transition period to lessen the immediate affects of prospective payment;

-- initially using prospective payment only for equipment costs which would lessen the immediate effects and provide some experience with prospective capital payment; and

-- modifing the cost reimbursement system by establishing limits to capital payments designed to remedy the same ills that PPS is supposed to.

Although we have not seen all the details of HHS's new prosposal, we understand that it includes a 10-year transition period to prospective payment for the capital costs of hospitals' plants with immediate coverage of the capital costs of equipment. The proposal would reduce payments by the levels specified in the 1986 reconciliation act mentioned above. This HHS proposal appears to be better than last year's and more or less incorporates two of our alternatives. However, we continue to believe our third option--modified cost reimbursement--is a viable option that could be targeted at problem hospitals.

The Fraud and Abuse Bill

In the last Congress, the House passed H.R. 1868, a bill designed to protect Medicare and Medicaid patients from incompetent practitioners and improve these programs' antifraud and abuse provisions. This Committee favorably reported a modified version of that bill, but the Senate was unable to act on it before adjournment. Major portions of this bill address gaps in HHS's practitioner sanctioning authority that we reported on in May 1984.[3] Other provisions were recommended by the HHS Inspector General. We testified in support of this and predessor bills three times.

While enactment of this bill would probably not result in large dollar savings, it would provide better protection for program beneficiaries from unfit or unethical practitioners and give HHS the tools it says it needs to combat fraud and abuse in Medicare and Medicaid.

Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs)

Medicare and Medicaid both contract with HMOs, CMPs, and similar capitated plans to provide care to beneficiaries. The administration has proposed and will this year propose initiatives to expand the use of these organizations by both programs. The concept behind HMOs and CMPs is good--pay a fixed amount per beneficiary for all covered services the beneficiaries need. The contractor assumes the risk, which in turn provides incentives to hold down costs. If the contractor succeeds in keeping costs down, it realizes a profit.

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[3] Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients From Health Practitioners Who Lose Their Licenses, GAO/HRD-84-53, May 1, 1984.

GAO has issued a number of reports since 1974 on Medicare and Medicaid use of HMOs, CMPs, and similar health plans.[4] The three general thrusts of those reports have been

- -- problems with setting payment rates,
- -- inadequate mechanisms to assure quality of care, and
- -- administrative problems in controlling enrollment and disenrollment of beneficiaries.

Our latest work in this area, Medicare's use of HMOs in Florida and the Arizona Medicaid program's use of CMPs, shows that these problems continue. Last year the Congress took action to strengthen quality-of-care controls and alleviate administrative problems. For example, outside medical review of HMOs with Medicare contracts was mandated, and enrollment and disenrollment issues were clarified. We also recommended that

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[4] Better Controls Needed for Health Maintenance Organizations Under Medicaid in California, B-164031(3), September 10, 1974; Deficiencies in Determining Payments to Prepaid Health Plans Under California's Medicaid Program, MWD-76-15, August 29, 1975; Relationships Between Nonprofit Prepaid Health Plans with California Medicaid Contracts and For-Profit Entities Affiliated with Them, HRD-77-4, November 1, 1976; Medicaid Insurance Contracts--Problems in Procuring, Administering, and Monitoring, HRD-77-106, January 23, 1978; Foundation Community Health Plan of the Medical Care Foundation of Sacramento, HRD-78-62, March 6, 1978; HEW's Contract with Group Health Cooperative of Puget Sound Covering Medical Care Provided to Medicare Beneficiaries--Noncompliance with Open Enrollment Requirements and Other Selected Issues, HRD-80-3, October 15, 1979; Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida, GAO/HRD-85-48, March 8, 1985; Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans, GAO/HRD-86-10, November 22, 1986, Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations, GAO/HRD-86-103, July 16, 1986

HHS take a number of actions, including improving its rate-setting methodology for Medicare.

We believe that it would be prudent to see if the changes that have been made are effective before launching major new efforts to expand the use of HMOs and CMPs by Medicare and Medicaid.

Overpriced Physician Procedures

When a new, complex medical procedure is introduced, physician charges for performing it are often high. Over time, more physicians become capable of performing the procedure, and improvements in techniques and technology can greatly reduce the risk of the procedure and the physician time necessary to perform it. However, in general the physician charges for the procedure stay high.

Last year the Congress required that payments for cataract surgery, a procedure that fits the pattern I just described, be reduced by 10 percent. The Congress has also directed the Physician Payment Assessment Commission to look for other overpriced procedures that are provided in quantity.

We believe this area presents a potential for significant savings. One example of a potentially overpriced procedure is cardiac pacemaker implants. During our work on Medicare payments to hospitals for pacemaker surgery patients,[5] we gathered operating room time data for 1,063 implants. When pacemakers were introduced, their implantation was considered relatively major surgery. Now, implants are generally done under local anesthesia, and in some hospitals implants are performed in areas other than operating rooms. Overall, about 100,000 pacemaker implantations are done a year.

The data we gathered showed average operating room times of a little less than 80 minutes for implantation of dual chamber pacemakers and about 50 minutes for single chamber pacemakers. The Medicare prevailing charge for pacemaker implantation vary by geographic area but were generally in the $1,000 to $1,500 range in 1986. Considering the physician time involved in implanting a pacemaker, the payment for this operation, and the decreased complexity of the procedure, pacemaker implantation may be overpriced.

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[5] Medicare's Policies and Prospective Payment Rates for Cardiac Pacemaker Surgeries Need Review and Revision, GAO/HRD-85-39, February 26, 1985.

Third-Party Liability

Medicaid has always been the payor of last resort; that is, any other insurance available to the recipient should pay before Medicaid. Since 1980, the Congress has enacted a series of provisions expanding the types of insurance that are primary to Medicare and has directed HHS to improve Medicaid third-party liability programs, as we recommended. Both programs have realized large savings from these actions.

Additional Medicare savings are available from better administration of its secondary payor program. I have with me advance copies of a report we will be issuing to the Committee's ranking minority member. This report recommends several actions to increase third-party liability savings on hospital costs. Implementation of those recommendations should save hundreds of millions of dollars for Medicare--we estimate that in 1985 Medicare paid at least $527 million in hospital costs that should have been covered by other insurers. We will also be looking at the administration of Medicare's secondary payor program for part B to see if savings can be increased there.

Medicare's Administrative Budget

In 1982 we testified about the savings that could be realized from expanding Medicare's cost effective programs of auditing provider cost reports and screening part B claims to identify claims for noncovered and unnecessary services.[6] The Congress provided $45 million in additional funding specifically for these activities in fiscal years 1983-85 and $105 million additional for these functions and the third-party liability program in fiscal year 1986. The Congress also authorized $105 million in additional funds for fiscal years 1987 and 1988.

Last year we reported and testified on Medicare's administrative budget for processing and paying claims.[7] The thrust was that we were concerned that the administration's efforts to cut the administrative budget were adversely affecting beneficiary and provider services and program safeguard activities. For example, average claims processing times had doubled, and many claims processing contractors were not meeting program safeguard standards.

Over the last few years the Congress has consistently appropriated more funds than the administration has requested for Medicare administration. We have not yet had the opportunity to analyze the administration's fiscal year 1988 budget request for Medicare administration but we would encourage the Congress to again take a hard look at the sufficiency of the request to assure adequate beneficiary and provider service as well as program safeguard activities.

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[6] Testimony on the President's Budget Proposals before the Subcommittee on Health, House Committee on Ways and Means, on June 15, 1982.

[7] Medicare: Existing Contracting Authority Can Provide for Effective Administration, GAO/HRD-86-48, April 22, 1986, and testimony on this report and related issues before the Subcommittee on Health, House Committee on Ways and Means, on May 1, 1986.

Home Health Care

One area that has consistently been of concern to this Subcommittee has been home health care. In fact, while the Congress has been acting to reduce costs in most other services, it has expanded benefits under home health care. One of the reasons for this is that home health care can be a cost-effective alternative to inpatient care.

Our latest report on home health care,[8] issued in December 1986, presents two different kinds of problems related to home health care. First, Medicare is not doing enough to assure that it only pays for services that are covered and medically necessary under current law. Second, there are a substantial number of persons who do not receive or have difficulty obtaining all the supportive services they need to stay in their homes. Such supportive activities include homemaker services, chore services, and meals on wheels, which are normally not covered under Medicare. We also point out that many people receive supportive services from family or friends and that covering these services under a government program could result in substitution of government-paid services for those currently provided by family and friends, thus increasing federal costs more than necessary to meet unmet needs only.

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[8] Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs, GAO/HRD-87-9, December 2, 1986.

Catastrophic Insurance for the Elderly

The final area I would like to discuss are the proposals that have been made to provide protection against catastrophic health care costs for the elderly. We believe that the information presented in our October 1986 report on Medigap insurance[9] will be useful to the Congress in considering these proposals. The information should be particularly useful regarding whether catastrophic protection for Medicare-covered services should be added to the Medicare program or whether the private sector should be encouraged to provide such protection.

We found that the loss ratio for the $1.3 billion in Medigap insurance policies sold by commercial insurers in 1984 averaged 60 percent; that is, only $0.60 of every $1 in earned premiums was returned to policyholders as benefits. For the 13 Blue Cross/Blue Shield plans included in our review, the average loss ratio was 81 percent for their $780 million in earned premiums in 1984. In contrast, Medicare pays about 97 percent of its costs as benefits. About $1 billion goes to the carriers and intermediaries for administering the program. Thus it appears that, in 1984 the private sector spent as much to administer the $5 billion Medigap market as the government paid the carriers and intermediaries to administer the $65 billion Medicare program.

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[9] Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies, GAO/HRD-87-8, October 17, 1986.

This concludes my prepared remarks. I would be glad to answer any question you have.

Senator MITCHELL. Dr. Altman.

STATEMENT OF DR. STUART ALTMAN, DEAN, HELLER GRADUATE SCHOOL, BRANDEIS UNIVERSITY, WALTHAM, MA

Dr. ALTMAN. Mr. Chairman, it is indeed a pleasure for me to be here this morning. I am here as a private citizen, although much of what I say will represent analysis that has been done by the Prospective Payment Assessment Commission, which I chair.

I would say at the outset, Mr. Chairman, that we have just completed two days of our meeting, and second to trying to figure out what to do with capital, we spent more time on trying to develop solutions for the problems of rural hospitals. And if you are interested, I would be glad to talk about rural hospitals in the discussion.

Let me just briefly indicate what my testimony focuses on. First, it focuses on the issue of combining Parts A and B under Medicare. I don't think there is anything more frustrating to those of us who have been trying to develop solutions is finding ourselves constantly frustrated by the fact that basically we have two Medicare programs, and they don't overlap. It is difficult to understand how one relates to the other. And if we have problems, the patients have far more serious problems.

I also would like to talk a little about coverage for long-term care.

We at Brandeis, with the help of the Senate Finance Committee, have been engaged in an experiment to combine long-term care coverage with HMO type coverage. And I am here to report that it is working. Thanks to Senator Durenberger and his staff, we were able to get a waiver to engage in this activity around the country. And while I am not suggesting here that it should be included tomorrow in the Medicare program, I do think it deserves to continue.

Third, I would like to touch on the issue of catastrophic coverage. I think it is very important in this day and age that we move forward with that, both for our Medicare population but also for our population in general.

I briefly discussed with Senator Kennedy's committee moving forward on mandating coverage for our working population.

And, finally, if time permits, I would like to give you our assessment of how the PPS system is working. I will tell you right up front that ProPAC's assessment is that with problems, it is working. The incentives are in the right place. The hospitals are not falling off the financial cliff. And, Mr. Chairman, I just might disagree with you a little bit. I think every assessment we have is that while there are some problems with respect to quality of care, the problems are not nearly as serious as some of the really dire critics would lead you to believe.

With respect to combining Part A and Part B, it may have made sense in 1965, although I think if you went around the room and talked to the panelists, I don't think it ever made sense to have a separate Part A and Part B. But it surely makes no sense now.

We no longer have a system which is, on the one hand, care in a hospital, and on the other hand, care in a physician's office. We have a continuum of care. Patients are treated all over the place. It is arbitrary, whether they are covered under A and B. It needs to be changed and it needs to be changed quickly.

I also think that we badly need to restructure the payment system for outpatient care. I appreciate that there is a new commission that you established, and two of the members are with me today, and I don't want to upstage them because they will probably do the same to me and it will be embarrassing. But someplace along the line, quickly, we need to develop a payment system for outpatient care that dovetails with our inpatient system.

We had a terrible problem in the 1970s, Mr. Chairman, when we artificially tried to control routine hospital care. And overnight, the accountants of this country modified routine hospital care. You could not find a routine duty nurse in this country. Everybody provided ancillary services. And so while every year OMB and the GAO estimated savings of hundreds of millions of dollars, it turned out we paid $4.82, because we moved it from one side of the ledger to the other. We will do the same thing between inpatient and outpatient. It really needs to be changed and quickly.

With respect to the long-term care coverage that I mentioned, the social HMO is an interesting experiment. It is being done in Minneapolis, in Portland, Oregon, and Long Beach, California, and in Brooklyn, New York. We have enrolled almost 12,000 individuals who are on the Medicare coverage. We are combining under the same dollar amount that Medicare pays for acute care, plus a small premium, we are providing these individuals not only with complete acute care but with long-term care institutional services as well as home care and social services. And it is being done because the people that run it manage the care, and the dollars they save on the inpatient side they use for the outpatient. It is working and I think it has good promise for the future.

With respect to coverage for the uninsured, the number of uninsured is growing very rapidly, and many of them are working. And, therefore, in my testimony I got into detail with respect to how to deal with it.

And, finally, as I indicated, we would caution you to be careful with those people who would tell you that we don't need to worry about our fee for service system because the panacea is right around the corner. We should go to complete vouchers and HMO coverage. I am a strong supporter of HMO coverage, but there would be nothing worst for that kind of coverage than to saddle managed care with being the dominant delivery system in this country.

We do that so often. We take a good idea that is working in a few states and mandate it for the country and it falls apart. We need to make our PPS system work better, fairer, for rural Americans, for urban hospitals. But I strongly urge you not to turn your back on PPS. It, in my view, will be around for the next five to 10 years and it needs to work better.

And as I said, our basic assessment is that it is working. And as I said, I would be glad to talk at length if you have further questions. Thank you, Mr. Chairman.

Senator MITCHELL. Thank you very much, Dr. Altman.

[The prepared written statement of Dr. Altman follows:]

Testimony
of
Stuart H. Altman, Ph.D.

Mr. Chairman, it is indeed a pleasure to appear before you and the Senate Finance Committee this morning to discuss possible changes in the Medicare and Medicaid programs. I appear before you as a private citizen, although some of my testimony is derived from analysis done by the staff of the Prospective Payment Assessment Commission of which I am the Chairman. Where appropriate I will also review decisions made by the Commission itself. As you know, the Prospective Payment Assessment Commission was created by the Congress in 1983 to advise it and the Administration on possible changes and adjustments in the Medicare PPS system. On April 1st, we will present the Secretary of the Department of Health and Human Services with our 3rd annual report.

In addition to discussing the impact of the new Medicare hospital payment system on the cost and quality of care, I would like to make a few comments about the need for Medicare to unify its in-hospital and out-of-hospital benefits and payment systems and to expand its coverage to protect individuals and their families against the ravaging economic effects of catastrophic and long-term illness. I will also address the need to expand employer based private insurance and Medicaid to help alleviate the problems of the uninsured and underinsured.

THE NEED FOR A UNIFIED MEDICARE BENEFIT AND PAYMENT SYSTEM

Mr. Chairman, I believe it is imperative that the Congress develop a new approach for paying for physician services and outpatient care under Medicare. Such an approach need not use the same mechanisms as created to pay for hospital services, but it is imperative that we avoid continuing a tight payment system for inpatient hospital services while we have a more lenient approach to paying for hospital outpatient care or physician services. In part, this has resulted in Medicare expenditures for inpatient hospital care growing by 6.8 percent in 1985 compared with outpatient hospital growth of 25.0 percent.

We learned the hard way during the 1970's that artificial distinctions by government that do not reflect reality in the medical system can create counter productive behavior by health-care providers as they attempt to maximize reimbursement. I am referring to the attempt by government under Section 223 of the Social Security Act to control hospital spending by limiting the amount paid for routine care and leaving ancillary care costs uncontrolled. Overnight accountants changed the nature of hospital care in this country by practically eliminating routine hospital care, at least with respect to what appeared on the books. Similar adjustments have already begun to take place concerning inpatient and outpatient hospital care.

I think Congress was wise to create the new Physician Payment Review Commission to help develop a new approach to paying for physician services and it would make sense to wait for their recommendations before proceeding to major changes in physician payment policy. Nevertheless, there is an important structural change in the Medicare program which Congress could legislate which would be helpful regardless of the ultimate option selected. I speak of the need to reexamine the partitioning of Medicare into two separate payment and benefit programs.

In 1965, when Medicare was enacted, the hospital and the physicians office were the major sites for the delivery of care. At that time, dividing Medicare into Part A for hospital care, and Part B for physician services was workable. Since then, new models of care and new models of financing have emerged. Increasingly, the Medicare program has experienced great difficulty in defining benefits and payment for treatment in new sites of care such as freestanding diagnostic and surgical facilities, hospice programs, and other acute and post acute care services. In an upcoming report on the impact of PPS on the American health-care system. ProPAC concludes that, "The time has come for a serious debate over the structure of Medicare benefits. The special needs of the elderly must be considered as our society moves away from provision of acute care services in the hospital." I would add to that conclusion the further justification that unless we discard the artificial separation of Part A and Part B and treat the whole health-care system as a continuum we will never be able to understand the interdependence of the system or fashion a truly effective cost control program.

The ProPAC report also highlights the negative impact of continuing two separate programs under Medicare on beneficiary access to care and the amount beneficiaries pay out-of-pocket. A separate cost sharing structure for each program often creates the unintended effect of increasing the amount paid by the patient if he acts in a way that saves the program money. For example, after a Medicare patient pays the initial hospital deductible, he pays nothing until the 61st day of care; all covered services provided in the hospital during the first 60 days are free to the patient. If the patient is asked or volunteers to go home from the hospital early and receives some of these services at home, a separate Part B payment is often required. These extra payments add up and do become a barrier to having patients move to what in total is the much more efficient locus for care.

Congress recently moderated the increase in the amount payed by Medicare beneficiaries upfront for hospital care (deductible), to compensate for the inappropriate increases in that deductible in the last few years which resulted from changes brought on by the PPS system and not from increases in the cost of hospital care. The Commission in this years report is likely to go further and recommend a restructuring of all hospital co-payment rates to be consistent with the incentives under PPS.

Partially as a result of PPS, admissions to inpatient hospital care and the length of stay for those who are hospitalized declined quite substantially after 1983. In combination, these two changes have greatly influenced the deceleration of Medicare spending. If these gains are to become permanent without a negative long-term impact on the the quality of care, Medicare beneficiaries must have access to appropriate post-discharge care. Such post hospital care, however, is often not considered a Part A benefit. As a result, the need for hospital discharge planning is increased, with no additional funding to meet this need. And as I just mentioned, beneficiaries find that they must pay all or a portion of the cost for an outpatient service that previously may have been provided to them for for free within the hospital. While I personally believe in the value of patient cost sharing, I do not think it should be over used, particularly for those services which can help to reduce overall expenditures. By focusing separately on spending levels for Part A and Part B and by imposing separate co-insurance and deductibles on each type of benefit, we are saving the system pennies, but costing it dollars, lots of dollars.

COVERAGE OF LONG-TERM CARE BENEFITS UNDER A MANAGED CARE SYSTEM (S/HMO)

The ability to save money and/or add coverage by adding cost saving services and offering a comprehensive benefit package under a managed care system, has been demonstrated repeatedly in well managed Health Maintenance Organizations. I therefore support the continued growth of the Medicare Health Maintenance option. In fact, I believe we should expand this option to include long-term care home health and institutional services provided they are offered in a combined managed care program and at a government premium rate that does not exceed the average expenditure level for similar type beneficiaries in their area. We at Brandeis University have developed such a program with the help of the Health Care Financing Administration under a special demonstration authority legislated by the Congress in 1984. The Social Health Maintenance Organization program (S/HMO) is in operation in four sites around the country, Brooklyn New York, Minneapolis Minnesota, Portland Oregon, and Long Beach California. While each program has a slightly different organizational setup, they all provide the same core services. In addition to all normal services covered under Medicare's Parts A and B, each program provides extensive amounts of home medical and social services and a limited amount of long-term institutional coverage. Medicare pays each plan the AAPCC (the average adjusted per capital cost) rate in the area and provides extra payment to the plan if an enrollee is considered eligible for institutionalization. In addition, the beneficiary is required to pay premium which is competitive with the amount charged for supplemental Medicare coverage in the area. Patients are also charged various levels of co-insurance for the expanded long-term care services.

The four plans have been enrolling subscribers since March 1985 and currently have a combined membership of over 11,000. Thus far, each plan has been able to offer the expanded coverage within the capitated amounts paid by Medicare plus the extra payments by beneficiaries.
A critical component of the S/HMO concept is the ability to manage the care offered and not institutionalize patients in a hospital or nursing home unless absolutely necessary. The dollars saved can be used to provide those home medical and social services which permit a patient to continue to function in a home environment. Such substitutions are taking place everyday and the program appears to be well received. For example, hospital utilization is well below fee-for-service levels at all sites, and the costs of the long-term care benefits are generally within budget levels. While the early results have been encouraging, I would not suggest you legislate such a modification in the entire

Medicare program until the S/HMO has been in operation for several more years and has been scientifically evaluated. Critical to the continuation of this demonstration, however, is the need for the Congress to extend the waiver authority which is scheduled to expire in the fall of 1988.

HELPING THE UNINSURED

Without diminishing the importance of modifying the Medicare program and expanding its benefits package to include long-term care services, this country has another serious medical care financing problem which needs to be addressed by your committee, Mr. Chairman. Since 1978, the number of Americans without any health-care insurance has grown by 32 percent and now is estimated to have reached a level of 37 million. In addition millions more working Americans have seen cutbacks in the coverage they do have. In combination, this has resulted in the percentage of total personal health care spending paid by the patient at time of use increasing for the first time in the last 50 years. This increase in the uninsured and under-insured has come just as many of the traditional sources of health care for these population groups are being forced to cutback the amount of free care they provide. Tightened government payments and more cost conscious purchasing by private health insurance plans has limited the ability of these providers to shift the expenses of the uninsured to others.

Some have suggested that we combat this problem by requiring providers to offer such free care and by restricting the amount of price competition within the health-care system. This approach, I believe, would be a big mistake. It would simply substitute one problem for another. Competition among providers of medical services and their increasing cost sensitivity, is the most effective method we have for controlling health-care spending. While permanent limits in overall health-care spending can be obtained through regulation, they require a degree of government control over the provision of health services that I do not believe the American people want its government to have. Much of the most effective cost control in this country has come through private sector initiatives such as the managed care techniques I mentioned previously. Reductions in hospital days of 20 to 25 percent have been recorded with the aid of second surgical opinions, pre-hospital certification, and the channeling of high cost patients to the most appropriate and efficient providers. The pressures for creating these spending control techniques have come from competition among price sensitive insurance carriers and alternative delivery systems.

Rather than restrict competition, we should focus attention on where the problem comes from - a lack adequate financing for the health care of certain population groups.

Earlier this month, I appeared before the Committee on Labor and Human Resources to discuss this same issue. In that testimony, I suggested that one component of a program to solve this problem is a federal mandate which requires all employers to provide a minimum level of health insurance to all their full-time employees. This would be a major first step, since 3/4 of the uninsured are working or are are part of a family with a working member. I also recognized, however, that it would not be a total solution to the problem.

What is also needed is a government program which builds on Medicaid and provides a similar set of minimum benefits including protection for catastrophic coverage. Such minimum protection need not be financed by government tax dollars. Instead, as several states have done, we could require that all private health insurers pay a portion of their premiums into an uninsurance pool. Such a program should be mandated by the federal government, but states would be permitted to operate the program if they wish.

I would also recommend that any such uninsurance pools be operated only in conjunction with a managed care system and an effective reimbursement approach. This is particularly important to limit the expense of the most costly cases. A number of private systems now in operation have shown the benefit of tightly managing such high cost cases.

ASSESSMENT OF THE PROSPECTIVE PAYMENT SYSTEM

If you will permit, Mr. Chairman, I would like to end my testimony with an assessment of the impact of the new reimbursement system for Medicare hospital benefits legislated by the Congress in 1983. I also would like to caution the committee about accepting too quickly the advice of those who believe that Medicare benefits will soon be paid through vouchers, thus making PPS and other fee for service reimbursement unnecessary. Much as I support the value of capitated payments, I believe it is neither desirable nor likely that we will operate our entire medical care system in this way in the near future.

When the new Medicare hospital reimbursement system was first introduced in 1983, there were critics who suggested that hundreds of hospitals would face serious financial difficulties immediately and that many of these would soon go bankrupt. Others forecasted that many thousands of Medicare beneficiaries would be denied needed services and suffer serious harmful medical effects. These critics warned that we faced the possibility of a significant decline in the quality of our hospital system. While I am not here to tell you, Mr. Chairman, that PPS has been implemented without problems, I can report to you that we at the Prospective Payment Assessment Commission can find no evidence of widespread financial problems for hospitals as a result of PPS or a serious decline in the quality of the medical care received by Medicare beneficiaries.

Quite the contrary, there is evidence to suggest that were it not for the flexibility given to hospitals under PPS to reduce their costs without suffering a corresponding reduction in reimbursement, many hospital would have faced

serious financial problems following the declines in in-patient admissions and length of stay beginning in 1983. While some credit for these changes in historical trends were a direct result of PPS, other factors were also working to cause these results. Most U.S. hospitals witnessed substantial improvements in their financial position since the introduction of PPS. One indicator of this is the growth in surplus funds as measured by what are called operating margins. In 1981 and 1982, just prior to PPS these margins averaged .02 of operating expenses. Since then, they have grown to .039 or almost a 100 percent improvement. Other indicators show similar trends.
Some recent statistics do show that the trend toward continued improvement in hospital financial conditions may be changing. A recent AHA report indicated that hospital operating margins declining by 17 percent for the first 8 months of 1986 compared to a similar period in 1985. Also we should be aware that these averages do hide segments of the system which do have problems, particularly some hospitals in rural areas and small urban facilities. But even these problems should not be blown out of context.

Of the more than 6000 community hospitals in this country in 1984, only 49 closed. In comparison, the annual closure amount was 33 in the period 1980-1983.

At the same time that hospitals were improving their financial conditions, the rate of growth of Medicare spending for hospital services was also improving. Medicare spending for inpatient hospital services which had been rising 17.6 percent per year between 1978 and 1982, exhibited a growth rate of half that or 8.7 per cent in the period since PPS, 1983-1985. While much of this slow down in hospital spending by Medicare can be attributed to the reduction in overall inflation, even after adjusting for changes in the prices of the goods and services bought by hospitals, annual inpatient Medicare spending per enrollee still declined in the 1983-85 period versus the pre-PPS period, (1978-82), by half.

There are others on this panel who will be quick to show you that much if not all of this improvement in Medicare inpatient spending has been counter balanced by the growth in spending for out-patient hospital services, physician care, and home health services. I would agree with their comments. However, it would be a mistake to draw the conclusion that therefore the PPS system was ineffective. Part of the growth in non-inpatient hospital care represents an expansion in services provided to Medicare beneficiaries--an expansion I believe we should be pleased to support. Individuals and families had been forced to go without valuable home based medical care because they could not afford it personally and their health insurance would not pay for it. While some had to enter an institution to receive such care, other just did without and suffered a reduction in their quality-of-life. The liberalization of home health coverage under Medicare predates PPS and the increase in spending for such services should be evaluated separately. A portion of the increase can also be attributed to a liberal payment system for outpatient care and no managed care program for such services which, as I mentioned in the beginning of my testimony, is seriously in need of change.

The other major concern about PPS - potential declines in quality of care - is more difficult to evaluate. Before trying to unravel its various components, let me again reiterate that ProPAC thus far has not been able to document a noticeable decline in the quality of total medical care provided Medicare beneficiaries since the start of PPS. It is an area of much concern to us, however, and we are devoting a substantial amount of our resources to monitor the situation and will report to you and the other relevant committees about what we find.

The problem of understanding this issue starts with the basic definition of quality: Is it a mechanical measure of the effectiveness of the medical care intervention; Is it a subjective assessment by patients about how they feel about the effectiveness of the medical intervention or about the process of their care, Is it the the patients perception about the change in the quality of their style of life; or, is it some measurable change in in functional status or health outcome. Each person may have a different definition, or variation on the ones I have suggested. Another problem relates to our lack of adequate measures about the quality of the medical care received before PPS. When it comes to understanding changes in the financial health of hospitals, we can look to measures before and after PPS. No such measures are available for the quality of medical care.

The term "quicker and sicker" has come into vogue since PPS. In part this is a true reflection of what the designers of PPS were hoping to create. There is no question that the incentives under PPS were clearly designed to encourage hospitals to develop methods whereby patients could be discharged from the most expensive site of the the health care as soon as reasonable. There is also little doubt that some of the patients discharged earlier since PPS was implemented were still in need of medical services that previously had been supplied in the hospital. An assessment of the quality of medical care must therefore include an an assessment of the availability and quality of services in a non-inpatient setting. Statistics indicate that the the amount of home health services, which had been increasing steadily during the 1970's, increased more more quickly after the introduction of PPS. Whereas these services were growing at about 22 per cent per year in the 1980-82 period, they grew over 31 percent in 1983 and then returned to the pre-1983 trend. Was this enough of an increase and did the quality of these home services measure up to what had been provided in the hospital? We don't know. We do know that the structure of the Medicare benefit system, as menitoned previously, required Medicare beneficiaries to pay for some of these services which previously had been free when provided in the hospital. I am sure this has led to some of resentment against PPS.

While some aspects of the phenomenon of earlier discharge are appropriate and should not lead to a deterioration in the quality of care, other behaviorial aspects are totally inappropriate and illegal. I speak of comments made by some hospitals and physicians that the Medicare program now only pays for a certain fixed number of days of care for a particular diagnosis or that the program does not cover a particular type of treatment. The DRG payment system is based on an average payment for each diagnostic category, recognizing that the treatment for any particular patient may fall above or below that average. If a hospital accepts all patients whose treatment costs or length of stay fall below the average and restricts access to care for those patients who require more that the average, the hospitals' actions are illegal. Just because this behavior is rewarded by the incentives in the system doesn't make such action unavoidable or appropriate. HCFA has established several mechanisms for stopping such practices. One of the most effective is a knowledgeable patient who reports such comments or behavior. ProPac has been urging the Department of Health and Human Services to publish booklets explaining in simple terms how PPS should operate and the types of behavior patients should be concerned about. Delays have occurred in the publication of these booklets, but we have been told they will be forthcoming shortly. I sincerely hope so.

In addition to monitoring the quality of the medical care received by Medicare beneficiaries, ProPAC is giving extensive attention to making sure that PPS payments continue to reflect our changing medical system. We are developing data and statistical techniques to better understand which medical diagnoses are being inappropriately reimbursed - too high or too low - and the types of hospitals that are gaining and losing under the system. In this connection we continue to analyze what changes will take place in the system as we move to national payment rates and the impact on different hospitals of the various approaches to paying for capital under PPS.

In conclusion, let me briefly voice my concerns about the suggestion that we don't need to worry about PPS since Medicare will soon be out of the provider reimbursement business. There is no question that it is appealing to to suggest limiting the government role in Medicare to to providing beneficiaries with a voucher amount, leaving

the choice of how to pay providers to the various delivery system alternatives. This is particularly appealing after working through the many problems of trying to design an effective reimbursement system for both inpatient and outpatient care and developing techniques for assuring that an acceptable level of care is provided to all beneficiaries. Nevertheless, my concerns are of two kinds:
(1) Can the Federal government really turn its back on being involved with the quality and cost of a service that it ultimately pays for; and (2) How would our total medical care system behave if it was made up entirely of cost conscious alternative delivery systems.

The issues involved in the first concern are obvious and have been debated many times before this committee. I believe that Congress made such a naive assumption in 1965 when Medicare was passed. This assumption was repudiated by the Congress in the 1971 Medicare amendments which imposed limitations, restrictions, and peer review requirements on the program. I find it hard to believe that we will return to the 1965 assumptions.

As an economist, I can appreciate the intrinsic value of a system which requires that every spending decision be made up front and not hidden through various "back door" funding schemes or cross-subsidy programs. As a political realist, however, I also realize that many worthwhile expenditures are only possible in such ways. Within the health field, for example, we look to the patient care reimbursement system to pay for the final stage of clinical research and evaluation of many new medical devices and procedures. Who would pay for such new techniques and procedures if all the delivery systems were cost conscious and interested only in the problems of today. Sure, we we could expand the NIH budget several fold or let such spending substantially decline, feeling that much of this spending is unnecessary anyway. I don't believe the latter and seriously questions whether as a political matter we would expand the NIH budget. Also, who will pay for the extra capacity that every community needs in case of medical emergencies? What HMO would be willing to run their hospitals at 15 to 20 percent under-capacity to help the community. For those HMOs or PPOs that buy their hospital care from community facilities, which ones would volunteer to pay an extra 10 to 15 percent to keep such needed redundancies around? How would graduate medical education be paid for; and what of the free care that will always be needed. It would be nice if we had a government program for each of these issues, but is it likely? Finally, can we be sure that the 80 to 90 percent of the physician and patient populations that are now not in an alternative delivery system would be willing over night to switch and behave like their colleagues who developed or have freely joined such options? Capitated or managed care delivery systems which represent 10 to 20 percent of the health care system have a very different impact than when they represent 80 percent. Why saddle a very worthwhile addition to our health-care system with the burden of overnight becoming the dominant delivery system. I strongly believe we would be doing a service to both managed care systems and our entire health-care delivery system if we let the managed care grow at its own pace rather than mandate its acceptance by everyone.

SUMMARY

In summary, Mr. Chairman, I would place the following items high on your agenda:

- Consider legislation to combine Medicare Parts A and B into a restructured benefit package. This benefit package should have uniform financial incentives and treat the health care delivery system as an interdependent continuum.

- Continue the careful experimentation being done in the S/HMO demonstrations in order to learn as much as possible about ways to provide long term care services to our citizens.

- Address the problems of the uninsured and underinsured through mandated employer coverage, expanded Medicaid coverage, and state-administered pools.

* Enact catastrophic coverge for Medicare beneficiaries and extend this type of coverage to all citizens through employer plans or Medicaid.

* Monitor and improve PPS; do not put off necessary changes in the expectation that a Medicare voucher program is possible or desirable in the next 5-10 years.

Mr. Chairman, I would like to thank you and the Committee for letting me appear before you this morning. I would be pleased to answer any questions you may have.

Senator MITCHELL. Dr. Davis.

STATEMENT OF DR. KAREN DAVIS, CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, SCHOOL OF HYGIENE AND PUBLIC HEALTH, THE JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD

Dr. DAVIS. Thank you, Mr. Chairman, for the opportunity to testify on the Medicare and Medicaid programs which are so essential to 50 million poor, old and disabled people in obtaining health care today.

Over the last six years significant changes in these programs have seriously undermined their adequacy in assuring health care for these vulnerable citizens.

Medicaid has been particularly hard hit. Numerous changes year by year have affected cutbacks in the eligibility benefits and in provider payments under the Medicaid program. This started in 1981 with the Omnibus Budget Reconciliation Act (OBRA) which reduced eligibility for the working poor. Congress rejected the Administration's cap on Medicaid, but in its place reduced the federal matching rate, putting pressure on states to cut back eligibility and benefits. Under OBEA states were permitted to cut hospital payments through a waiver and limit the freedom of choice for Medicaid beneficiaries to choose their own provider. OBRA did, however, include an important expansion of coverage for in-home and community-based services.

Again, in 1982, Medicaid was cut under TEFRA which permitted states to impose cost sharing for Medicaid beneficiaries.

The Deficit Reduction Act of 1984 started a reversal in this trend to cut the Medicaid program by covering children on an incremental basis up to the age of 5 whose income fell below state income standards, as well as certain groups of pregnant women with incomes below state income standards.

The Gramm-Rudman-Hollings bill recognized the importance of Medicaid as a safety net program and exempted Medicaid from across the board budgetary reduction.

The Comprehensive Omnibus Budget Reconciliation Act of 1985 brought coverage of all pregnant women with incomes under state income standards.

And then, most importantly, the OBRA bill of 1986 permitted states, on a voluntary basis, to cover elderly people, disabled people, children up to age 5 on an incremental basis, and pregnant women up to the federal poverty level. It broke the link of Medicaid eligibility to the AFDC eligibility level by permitting states to cover the poor up to the federal poverty level.

States have also been cutting back on program benefits and provider rates, but, most importantly, states have not increased income eligibility levels to keep pace with inflation. So that states like West Virginia, in 1983, set the income eligibility level at 30 percent of the federal poverty level, while Maine set the income eligibility and at about 50 percent of the federal poverty level.

Medicare has fared only slightly better than the Medicaid program. In 1981, the deductibles under Part A and Part B were increased. Part B increased from $60.00 to $75.00. Part A was increased in the base year, with additional annual increases in hospital costs per day. We have seen the deductible for hospital care, for example, go up from $180.00 in 1980 to $520.00 today. It would have increased even higher without action by the Congress last year.

Medicaid and Medicare together are an important safety net; however, there are many gaps in the safety net and it has worn thin in many places.

Dr. Altman mentioned the 37 million people without any health insurance in this country. Medicaid simply does not cover all of the poor; it covers less than 40 percent of the poor. And among the poor aged, Medicaid supplements Medicare for only 30 percent of the poor elderly.

Medicare improvement is particularly important. We do need adequate catastrophic protection. I would endorse Dr. Altman's proposal to merge Part A and B and impose a ceiling on out of pocket expenses that the elderly would pay for their acute health care benefits of say, $1,250 or so, per year.

I think it is also important to look toward further improvements in Medicare, such as a new part of Medicare to provide long-term care and eliminating the 2-year waiting period for the disabled under the Medicare program.

I also endorse Dr. Altman's suggestion that we provide catastrophic protection for the working population, and would urge that employers be required to provide at least a minimum catastrophic plan for all employees and their dependents. The plan should also include maternity and infant care.

Medicaid should be improved to be a genuine safety net for the poor. That means a minimum income standard set at about 60 percent of the poverty level, for example, would make sure that even states that now cover very few of the poor would cover at least some minimum level.

We need to address the problem of spouses who are impoverished when a spouse is placed in a nursing home and who use Medicaid as a catastrophic program of last resort. We need to guarantee eligibility under Medicaid, or catastrophic expenses of anyone not covered under Medicare or an employer plan.

I know that the Congress faces budgetary constraints, but that we need to assure some minimum adequate safety net for our entire population.

Thank you.

Senator MITCHELL. Thank you, Dr. Davis.

[The prepared written statement of Dr. Davis follows:]

MEDICARE AND MEDICAID IN THE REAGAN ERA

Karen Davis

Thank you, Mr. Chairman, for this opportunity to testify on important changes in the Medicare and Medicaid programs in the last six years. Medicare and Medicaid finance health care bills for 50 million of our most vulnerable people. They enable many poor, old, or disabled people to obtain needed health care services and protect against the financial hardship that medical bills can bring.

Despite their recognized importance in protecting some of the most vulnerable of American society, Medicare and Medicaid have been affected by the budgetary climate of the past six years. Medicaid has been particularly hard hit, but Medicare has also proved to be increasingly inadequate in protecting elderly and disabled beneficiaries from burdensome health care bills. Today, I would like to summarize some of the most significant changes in the Medicaid and Medicare programs over the past six years and suggest some immediate and longer term changes that are required to assure that these programs live up to their original promise.

I. Medicaid Changes

Legislative changes in Medicaid have occurred almost annually since 1981. Early changes focused on cutbacks in eligibility, benefits, and provider payments. Congress legislated important expansions in Medicaid coverage in 1984 and 1986, but these have not offset the failure of states to adjust eligibility for inflation. The most important of these changes include:

OBRA 1981 -- The Omnibus Budget and Reconciliation Act of 1981 reduced eligibility under the Aid to Families with Dependent Children (AFDC) program for the working poor, which automatically limited Medicaid eligibility. The federal financial matching rate was reduced 3 percent in 1982, 4 percent in 1983, and 4.5 percent in 1984 -- thus creating pressure on state governments to reduce eligibility, benefits, and provider payments. States were given greater flexibility to cut the program including cutting the link of Medicaid hospital payment rules to Medicare provisions and permitting states to obtain waivers to limit freedom of beneficiaries to choose their own physicians, hospitals, and other providers. One important expansion in the 1981 law was a waiver provision permitting states to provide in-home and community-based services for the disabled and frail elderly.

TEFRA 1982 -- The Tax Equity and Fiscal Responsibility Act of 1982 permitted states to impose cost-sharing charges on basic health care services for welfare recipients.

DEFRA 1984 -- The Deficit Reduction Act of 1984 contained the first significant attempt to expand Medicaid eligibility. Newly covered groups included children up to the age of five years in families with incomes below state income standards, and mandatory coverage of pregnant women below state income standards who would be eligible as "unborn children" or AFDC-Unemployed Parents if the state had exercised optional provisions in the law. This new Medicaid coverage did not require expansion of welfare coverage.

Gramm Rudman Hollings 1985 -- The Gramm Rudman Hollings law recognized the importance of Medicaid and exempted Medicaid from across-the-board budgetary reductions.

COBRA 1985 -- The Consolidated Omnibus Budget Reconciliation Act of 1985 brought coverage for all pregnant women in families with incomes below state income standards, and included sixty days of postpartum coverage.

OBRA 1986 -- The Omnibus Budget Reconcilation Act of 1986 created an important split in the link between Medicaid and welfare coverage. It permitted states on a voluntary basis to cover the elderly, disabled, children up to age five (on an incremental basis), and pregnant women up to the federal poverty level -- even if these individuals' incomes are above welfare assistance levels. This Medicaid expansion was significant in setting a Medicaid income level not tied to welfare assistance.

State Actions -- State changes in Medicaid are more difficult to characterize. During the 1980s states have limited Medicaid benefits by amount, duration, and scope. Utilization review measures have further restricted when services are covered. Provider payment rates for hospitals as well as physicians have been sharply curtailed. Some states have restricted provider participation to only those hospitals or HMOs winning competitive bids. Most importantly, states have rarely raised the income eligibility standard to keep pace with inflation.

II. Medicare Changes

Medicare has fared only slightly better in the last few years than Medicaid. The Congress has followed a policy of requiring that Medicare budgetary cuts not harm beneficiaries. Benefits and eligibility have remained intact, but cuts in provider payment rates were made. Limits on provider payments have not yet reduced the willingness of hospitals and physicians to accept Medicare patients. Yet older and disabled Americans have felt the brunt of rapid increases in health care costs that leave them struggling with out-of-pocket payments for health care services.

The Medicare Part A and Part B deductibles were increased by OBRA in 1981. This raised the deductible for physician and other Part B services from $60 to $75. The 1981 law rebased the Part A deductible (effectively increasing the 1966 base deductible from $40 to $45). With annual increases in hospital costs per day (that have been particularly acute in recent years as hospitals have shortened the length of hospital stay) have led to an increase in the hospital deductible from $180 in 1980 to $492 in 1986. This deductible is three times higher in real (inflation-adjusted) terms than the original level. Legislative action by the Congress held the deductible to $520 in 1987. Skilled nursing home copayments and hospital copayments after the 60th day of hospital care are linked to the hospital first day deductible, and have experienced similar increases.

Medicare changed hospital payment methods in TEFRA 1982, and then adopted the Diagnosis-Related-Group Prospective Payment System for hospitals in 1983. Physician payment and participation rules have also been changed beginning in 1984. To date these changes do not appear to have affected the willingness of hospitals and physicians to care for Medicare beneficiaries, but they have led to some changes in the practice of health care that may create some hardship for beneficiaries. Earlier hospital discharge, for example, may lead to convalescence at home without adequate support; this is particularly a concern for the 30 percent of older Americans who live alone. Earlier hospital discharge and outpatient surgery, in addition, may shift some expenses onto beneficiaries as services that would have been covered fully during the hospital stay are covered partially or not at all.

III. Future Directions

Medicaid and Medicare constitute an important safety net in ensuring access to essential health care services for the most vulnerable members of American society. Yet, this safety net has serious holes, and has worn threadbare in many places. Thirty-seven million Americans have no health insurance coverage. Most poor are not covered by Medicaid -- over 60 percent of the poor under age 65 are not covered by Medicaid and 70 percent of the elderly poor do not receive Medicaid to supplement Medicare. Medicare pays only 45 percent of the $4,202 spent in 1984 on health care for people age 65 and over. Those with multiple hospital stays and ongoing chronic health problems face very serious financial burdens -- from Medicare cost-sharing requirements and noncovered services.

Medicare Improvements -- The most important immediate change required in the Medicare program is addition of adequate catastrophic protection. This would include a maximum ceiling on out-of-pocket expenses for Part A and Part B services of, say, $1,250 per year, imposition of only one hospital deductible per year, and removal of the limit on covered hospital days. A tax-financed improvement in Medicare would have the advantage of making this necessary protection automatically available to all Medicare beneficiaries and avoid the burdens that an increased premium can pose for many poor, near-poor, and modest income older people. In the longer term, Medicare should remove the two-year wait for eligibility of the disabled, and long-term care benefits for the elderly and disabled should eventually be added to Medicare through a new part of the program.

Improvements for the Working Population -- Catastrophic protection and access to health care services for the non-elderly population is also extremely important. Nearly all of the 37 million uninsured Americans are age 65 and under; the majority are in families with a working member. Yet, they do not receive health insurance coverage through their employer. Another 10 million do not receive adequate protection against catastrophic expenses.

The most important step that could be taken to assure minimum protection for the working population would be to require employers to provide catastrophic health insurance coverage to all workers and dependents. This could include requiring that the plan place a maximum ceiling on out-of-pocket expenses for a basic benefit package of $2,500 per family, or $1,250 for an individual. Comprehensive coverage of maternity and infant care should be a part of any minimum benefit package, to assure a healthy start in life for children of working families. Employers could be required to pick up at least 75 percent of the premium for this coverage. To avoid adverse employment effects on employers of low-wage workers, some consideration could be given to offsetting tax credits for employers experiencing an increase in labor costs in excess of a given percentage of payroll.

Medicaid Improvements -- Medicaid should be restructured to provide a genuine safety net for those at the lowest end of the income ladder and to provide catastrophic protection as a last resort for those without such coverage from Medicare or an employer plan. This would include establishing a minimum income floor tied to the federal poverty level -- set initially at least at 60 percent of the federal poverty level. Currently, 39 states have income eligibility levels for Medicaid set at below 60 percent of the federal poverty level. Over time, this minimum floor should be raised to 100 percent of the federal poverty level.

Medicaid eligibility should also be extended to assure some catastrophic protection for those not otherwise protected. For example, Medicaid eligibility could automatically be conferred for one year for any family incurring out-of-pocket expenses for hospital, physician, and other acute care services in excess of $2,500 or 15 percent of family income.

These proposals are advanced cognizant of the difficult budgetary choices the Congress faces. They are designed in an incremental fashion, and may be modified to accommodate to available budgetary resources. They place maximum emphasis on private coverage for those in the workforce, but provide a compassionate last resort for those who have no other recourse except Medicare and Medicaid. This nation can do no less than assure that economic and budgetary pressures do not cause us to lose sight of the importance of assuring access to essential health care services to all of our population. Thank you.

Senator MITCHELL. Dr. Meyer.

STATEMENT OF JACK A. MEYER, PH.D., NEW DIRECTIONS FOR POLICY, WASHINGTON, DC

Dr. MEYER. Thank you, Mr. Chairman.

I would like to start by emphasizing the importance of welfare reform to health. We have a situation where the ratio of one state's AFDC payment standard to another state's standard can be as high as 5 to 1. We could talk about the fact that it was difficult in 1986 for a family of four in Alabama to live on $1764.00 a year, which is 16 percent of the poverty line. That was the maximum benefit under AFDC in that state. But, the importance for our subject today is what that does to health care. And the point is that when you are ineligible for AFDC or SSI, you are typically also screened out of Medicaid.

We need to set some kind of a federal floor on benefits.

In a recent report, I have advocated setting a sum of AFDC plus food stamps at 65 percent of the poverty line.

Second, I think we need to uncouple Medicaid further from the vagaries of the welfare system, wherever we set the floor. I have recommended a floor of 65 percent of poverty; others say 50 percent. We ought to take further steps to require that, regardless of where such a floor is set, more people who are ineligible for cash assistance, but poor, receive Medicaid.

Congress took an important step last year to make that optional for the states. I think we have to take some of our optionally categorically needy groups and make health coverage mandatory for them.

I don't think that all the poor have to be necessarily covered by Medicaid, because many of them are working. We need further steps, as Stuart has mentioned, to encourage private sector coverage for those, but we also need a good safety net for people who cannot obtain employment-based private insurance.

Third, I think we need greater emphasis on case management in Medicaid and fair fees for providers. We have discovered states that pay $7.00 or $8.00 to a physician under Medicaid for an office visit. That encourages the physician to shun Medicaid enrollees. And then they end up in the emergency room spending more and getting insufficient primary and preventive care.

There are experiments to raise fees and also have risk sharing arrangements with doctors under Medicaid, but there has been little effort to organize the results of these pilot projects. We need to extend them further to put doctors at risk, but also give them incentives to participate in the Medicaid program.

In short, there needs to be much more emphasis on access and primary and preventive care, and you don't do that by squeezing fees, a lesson I will comment on in a moment, for Medicare.

I think we also need to address the issue of long-term care. Very briefly, I believe in a public-private combined approach to this that starts with the fact that the public program, Medicaid, has to be graduated to need and not all or nothing.

You now have a process in which you have a deep descent with no cushion until you become a pauper. And then when you get down to $2,000 to your name, or less, and get through the waiting list, you might get government-paid aid for a nursing home, but for nothing else.

I don't see any reason to make it all or nothing. I think we could have subsidies scaled to income, relying on a premium that would be partially subsidized for the near poor: as income rose, your subsidy would shrink. But you would get a little help as you start paying more, instead of becoming a pauper first.

The government should put some money into this system. It will cost money. I have some ideas on how to finance that, including premium increases or the taxation of more benefits. I agree with Karen that to rely on heavy cost sharing would not be the proper way to finance additional coverage.

In the area of Medicare, very briefly, there are two categories I want to talk about. One, benefit redesign and the other, payment system reform.

First, as other panelists have mentioned, we need to build a catastrophic feature into Medicare. I am not so concerned at this point whether it is $2,000 or some other number. Frankly, I think there is something to be said for varying the cap or stop loss with income, if it can be done administratively. $2,000 may be too high for the near poor. At the same time there are others who could afford a little more, though not necessarily $15,000.

But I think that we should take other steps in reforming the Medicare program. Medicare is still a first dollar type program, despite the 1-day deductible, and it is still biased toward institutional care. This should be changed.

We need more emphasis on outpatient care and prevention. Medicare will cover things that cost 25,000 dollars, but at the same time it won't cover an annual physical. This surely seems penny-wise and pound-foolish.

We need more emphasis on prevention and benefit redesign, and also on outpatient care. If you look at something like the psychiatric benefit, thousands of dollars will be paid inpatient, with a cap of 190 days, but there was a cap the last time I looked of $250.00 per year on outpatient care, encouraging the care in a high-cost institution.

Finally, in the area of payment system reform, I think we need to start with the idea that we need fair DRG rates and to refine them. If you don't put money into the system, you will defeat the purpose. If you want to take away the savings every time a hospital gets it, you also defeat the purpose. You need to update those rates fairly, and there will be a temptation to squeeze them.

I think we need to move away from the CPR physician payment system, which is an anachronism. It has to be scrapped. But we have to have something we know how to do. We cannot just rush into DRGs for doctors if we don't know how to do it. Maybe a fee schedule is an interim step.

I think we ought to move toward a voucher for all of Medicare. I like the idea of combining A and B. DRGs and the new way of paying HMOs ought to be a step toward a more pluralistic environment. As I think Stuart mentioned, you don't want to pick one idea and push it only. Though 95 percent of payment for HMOs is a good step, it should be broadened to all qualified plans, with more competition among all types of plans, and a pluralistic environment.

I think it would be a dreadful mistake to squeeze these fees. We need structural reform, not freezes and caps. Whether we're talking about a Medicaid cap or a physician fee freeze, such steps just buy us time at best. They have adverse side effects. I would prefer to get on with the business of making structural changes.

Thank you.

Senator MITCHELL. Thank you, Dr. Meyer. Dr. Palmer.

STATEMENT OF JOHN L. PALMER, PH.D., SENIOR FELLOW, THE URBAN INSTITUTE, WASHINGTON, DC

Mr. PALMER. Dr. Meyer is a hard act to follow. Let's see if my timing is good too.

I am pleased to be here this morning. Let me first say something about the recent history of the Medicaid program.

There is no doubt that cost containment efforts in the Medicaid program over the past six years have met with considerable success. After rising at an annual rate in excess of 5 percent annually throughout the 1970s, real Medicaid expenditures did not grow at all from 1982 to 1984, and are averaging only 2 to 3 percent per year growth more recently. Some of this major slowing in growth in the early period was due to recession—induced budgetary stringencies at the state level, but the program changes dating back to the 1981 Omnibus Reconciliation Act have clearly also been a major factor.

This cost containment reflects, in part, measures that may have improved the cost effectiveness of Medicare expenditures in some respect, but it has also clearly come at the expense of reduced access to needed medical care for the low income population, particularly for the non-elderly. For example, the proportion of the non-aged poor who are covered by the Medicaid program, which is already quite low, declined substantially in the first half of the 1980s. Fewer physicians are participating in Medicaid because of reduced real fees, particularly in important specialties, such as obstetrics, and Medicaid recipients are having to depend much more on public hospitals and less on voluntary institutions who won't accept them.

For these reasons, I think any further cuts in Medicaid are likely to exacerbate growing access problems, and should be approached with considerable caution.

In my view, a higher priority should be given to provide expanding it, not reducing coverage to the lower income population, in many of the ways that earlier panelists have talked about.

Now let me turn to Medicare. I conducted analyses of the effects of recent changes in Medicare comparable to those that we have done for Medicaid, except to document that program changes over the past six years have lowered projected expenditures and raised projected revenues by between 15 and 20 percent. These changes have had the saluatory effect of slowing the rapidly rising burden on general revenues for the financing of SMI, and of postponing the projected bankruptcy of the HI trust fund until the mid to late 1990s. However, despite this sizeable shift in Medicare's fiscal outlook, the conjunction of continued rapid escalation overall health care costs with the increasing need for health care services among the nation's elderly will create increasingly severe policy dilemmas.

What is often not so apparent from much of the discussion now going on about the future of Medicare, and what I want to emphasize today, is the dimension of the fiscal imperative the program still faces. Quite independent of the desirability of any particular reform options, I believe fiscal realities and expanding needs will require a radical restructuring of the program in the not very distant future.

Medicare still faces a far greater fiscal problem than did Social Security a few years back. In all likelihood, by early next century, simply maintaining current services would require that Medicare's currently projected revenues be halved or the current tax burden doubled, or some combination of the two. Concern about a much smaller Social Security problem prompted the Ninety-eighth Congress to undertake the most thoroughgoing rethinking of that program since the 1930s. Medicare promises to be a much more complex and still thornier issue.

I think it is important that the fiscal reprive that has been bought by the recent changes in the Medicare program be used to plan sensibly for the longer run future of the program. There is considerable risk in either allowing short-term federal budgetary pressures to drive Medicare policy in directions that don't make long-term sense, or in being lulled into thinking that much needed expansions in the program can be easily accommodated in the longer run.

I don't have any specific prescriptions to offer right now for the longer run future of Medicare, but I do want to make the following observations about its general direction in conclusion.

First, it is clear that at the same that some expansions in the program are needed, some substantial sacrifices will ultimately have to be made by providers, taxpayers and beneficiaries alike.

Second, unless a substantial hardship is going to be visited on the aged of modest means, imposing greater financial costs on the aged will inevitably have to involve some differential treatment by income level. There are ways of doing this while retaining the universal eligibility features of Medicare, but they pose difficult design and administrative issues.

Finally, more aggressive restraints for provider reimbursement will likely require the nation to ultimately choose between two very different philosophical approaches and practical roles for the federal government.

One approach would be largely confined to continued changes in Medicare reimbursement, such as those that have been pursued for the past several years and are now advocated by the Reagan Administration. It would entail less change in our overall health care system, but will inevitably result in different styles of medicare care for different segments of the aged. The alternative path is to move more in the direction of a national system of health care budgeting and cost control affecting all payers and providers. Needless to say, such a system would entail a very dramatic and controversial change in the nature of our health care system.

Thank you.

Senator MITCHELL. Thank you, Dr. Palmer.

[The prepared written statement of Dr. Palmer follows:]

PROBLEMS AND PROSPECTS FOR MEDICARE AND MEDICAID

Statement Before the
Senate Finance Committee
Overview Hearings on the Medicare
and Medicaid Programs
January 29, 1987

by

John Holahan
and
John L. Palmer*

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* Director, Center for Health Policy Research, and Senior Fellow, The Urban Institute, respectively. The views contained in the statement are those of the authors and should not be attributed to The Urban Institute.

We will briefly discuss Medicaid and Medicare in the time alloted to us, drawing on our ongoing analyses of the recent history and prospects for both programs.* Regarding Medicaid, our focus will be on summarizing our major finding on the consequences of the program changes that have taken place over the past six years and indicating some of the problems and issues raised by these changes; whereas for Medicare it will be on the dimensions of the fiscal problems still facing the program and their implications for future program reforms.

Medicaid

The high real growth rates in Medicaid spending (greater than 5 percent per year) experienced throughout the 1970s made the program a prime target for Reagan Administration budget-cutting efforts. The response was the major changes in the program incorporated in the Omnibus Budget Reconciliation Act of 1981. That legislation reduced federal matching grants, made direct reductions in eligibility particularly affecting the working poor, allowed states to adopt new methods of paying for hospital inpatient care, and permitted states to move away from freedom of choice in paying for ambulatory care, and to establish home and community-based waiver programs as alternatives to institutional long-term care.

Since 1981 real Medicaid expenditures have increased much more slowly, as there was essentially no growth from 1981-1984 and only two to three percent annually since then. The decline in the growth in program spending was due to the OBRA program changes as well as to state budget stringencies resulting from the 1981-1982 recession. Eligibility reductions following OBRA accounted for some of the reduced program growth. In addition, states adopted prospective payment systems for hospital inpatient care, reduced physician fees, and contracted coverage of optional services such as dental care, podiatrists, chiropractors, optometrists, etc. Also, the growth in coverage of the mentally retarded in intermediate care facilities, which was a major factor in the late 1970s when states shifted from state institutions to Medicaid-covered facilities, no longer continued to be a source of rapid growth.

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* John Holahan and Joel Cohen, Medicaid: The Cost Containment-Access Tradeoff, The Urban Institute Press (forthcoming); and John Holahan and John L. Palmer, "Medicare's Fiscal Problems: An Imperative for Reform," Discussion Paper, Changing Domestic Priorities Project, The Urban Institute, February 1987. (Medicare's Fiscal Problems: An Imperative for Reform, a discussion paper is retained in the Committee files.)

The record of the post-1981 era is therefore one of considerable state success in cost containment. In part this reflects better targeting of benefits, e.g., reductions in the richness of service coverage, reductions in hospital payments, and use of utilization control policies to better target optional services. But this cost containment also has been achieved at the expense of program services, particularly for the non-aged. The program now covers an even smaller share of non-aged individuals in poverty than it did in 1981. (The number of children covered by Medicaid increased by 3 percent between 1980 and 1984, while the number of children in poverty grew by 37 percent.) Reductions in physician fees in real terms has led to reductions in physician participation, particularly for specialties such as obstetrics. As a result, Medicaid recipients experience severe difficulties in obtaining access to physician care. And while there is no indication that Medicaid recipients have more difficulty obtaining access to hospital inpatient care, there is a clear shift in the share of days provided by voluntary institutions toward public hospitals. Finally, Medicaid reimbursement policies appear partially responsible for the nursing home bed supply not keeping up with the growth in the elderly population.

Any further budget cuts in the Medicaid program are likely to exacerbate these growing access problems for the low income population, and for this reason should be approached with considerable caution. In our view a higher priority should be given to providing broader, not reduced, coverage to the low income population by reducing the wide disparity in Medicaid benefits across states.

Medicare

We have not conducted analyses of Medicare comparable to those we did for Medicaid, except to document that program changes over the past six years have served to lower projected expenditures and raise projected revenues by between 15 and 20 percent relative to such projections under prior policies. These changes have had the salutory effect of slowing the rapidly rising burden on general revenues for the financing of SMI and of postponing the projected bankruptcy of the HI trust funds until the mid to late 1990s. However, despite this sizeable shift in Medicare's fiscal outlook, the conjunction of continued rapid escalation of overall health care costs--which have not slowed appreciably in real terms in the 1980s--with increasing need for health care services among the nation's elderly will create increasingly severe policy dilemmas for the future of the Medicare program. A public debate of sorts on the need for more substantial program reforms seems to be beginning and numerous analysts and public figures are performing a valuable service by laying out various concerns that might be considered in any reform effort. But what is not so apparent from much of the discussion so far, and which we therefore want to emphasize today, is the dimension of the fiscal imperative facing the program. Quite independent of the desirability of any particular reform option and of the effectiveness of any of the recently enacted reforms, we believe fiscal realities will require a radical restructuring of the program in the not very distant future. Medicare, in fact, still faces a far greater fiscal problem than did the Social Security program a few years back. In all likelihood, either Medicare's currently projected expenditure will have to be halved or current tax burden doubled--or some combination of the two--within the next 20 to 40 years. Concern about a much smaller Social Security problem prompted Congress to undertake the most thorough-going rethinking of that program since the 1930s in 1983. Because of its far greater complexity and the depth of its fiscal distress, Medicare promises to prove a still thornier political problem.

Our concern is that the reprieve that has been bought by the recent changes in the Medicare program be used to plan sensibly for the longer run future of the program. There is considerable risk in either allowing short-term federal budgetary pressures to drive Medicare policy or in being lulled into thinking that major expansions in the Medicare program can be easily accommodated in the longer run. We do not have any specific prescriptions at this time for the longer run future for Medicare, but we do want to offer the following observations in conclusion.

First, it is clear that some substantial sacrifices will ultimately have to be made by providers, taxpayers, and beneficiaries alike.

Second, unless a substantial hardship is going to be visited on the aged of modest means, proposing greater financial costs on the aged will inevitably have to involve some differential treatment by income level. There are, of course, ways of doing this while still retaining the universal eligibility feature of Medicare, but they will inevitably pose difficult design and administrative issues.

Finally, more aggressive restraints for provider reimbursement will likely require the nation to utlimately choose between two very different philosophical approaches and practical roles for the federal government. One approach would be largely confined to continued changes in Medicare reimbursement, such as those that have been pursued for the past several years and are now advocated by the Reagan Administration. It would entail less change in our overall health care system, but will inevitably result in different styles of medical care for different segments of the aged. The alternative path would be to move more to a national system of health care budgeting and cost control affecting all payers and providers. Needless to say, such a system would entail a very dramatic and controversial change in the nature of our health care system.

Senator MITCHELL. Miss Polich.

STATEMENT OF MS. CYNTHIA POLICH, EXECUTIVE VICE PRESIDENT, INTERSTUDY, EXCELSIOR, MN

Ms. POLICH. Thank you. I am very pleased to be here. I am with InterStudy, a non-profit health care research organization located just outside of Minneapolis, Minnesota where I am pleased to say has about one-tenth the snow that you have here.

For over a decade, InterStudy has been involved in promoting and monitoring the development of managed care systems and capitation financing. In the past two years, we have spent considerable time examining the appropriateness of managed care system and capitation for the Medicare population. I would like to concentrate my opening remarks on some of the key findings of our work in this area.

Not surprisingly, our research has shown that the current system of providing health care to the elderly is marred by at least two major flaws. First, it is excessively costly to both the public sector and Medicare beneficiaries. Second, the system is fragmented and biased toward acute care, even though the high prevalence of chronic conditions among the elderly creates a need for an integrated system that includes both acute and long-term care services. Given these major flaws, any reform of Medicare should be guided by two broad goals: the integration of acute and long-term care into one package and the capitation of Medicare benefits to control costs.

For these reasons, we are very supportive of the federal government's current efforts to encourage Medicare enrollment in HMOs. We are also closely following the progress of the Social/HMO demonstration projects as a promising method to accomplish both the goals we have identified. We strongly believe that this is the direction that the Medicare program should head. And I would urge you not to pull back on current efforts to expand Medicare capitation due to problems identified in Florida.

Other areas of the country, including my home state, where seven HMOs with TEFRA-risk contracts enroll over 50 percent of the Twin Cities' Medicare beneficiaries provides substantial evidence of how well this approach can work. But it is also clear that several issues and problems with Medicare capitation must be resolved.

One of the keys to the success of Medicare capitation is the development of an appropriate methodology for determining the capitation rate. If the capitation rate does not adequately reflect the real costs incurred by HMOs, they may be significantly overpaid or underpaid for the services they provide to their enrollees. There is a great deal of evidence that the current use of the AAPCC is very inadequate, only explaining approximately 1 percent of the variation in costs for Medicare beneficiaries in HMOs. Because of this, we strongly recommend that a new formula for determining the capitation level, preferably including some type of case mix adjustment, be developed very soon.

Quality of care is another important issue that must be dealt with if Medicare risk contracting is to be successful in the long term. While it is generally agreed that capitation financing provides incentives to contain costs, some also suggest that capitation may result in inferior quality or underservice because of the strong focus on saving money. Clearly, much more needs to be done to develop adequate quality assurance mechanisms and to demonstrate that the care provided through managed care systems is of adequate quality. I personally believe that it is.

Quality of care, however, has two components. It not only involves the question of whether the services provided are of high quality, but also whether the entire service package is appropriate and complete. For the elderly, this means that a wide range of coordinated acute and long-term care services must be provided. HMOs have the potential to improve the health and long-term care system for the elderly because they are designed to integrate a wide range of services and providers.

For HMOs to achieve this potential, however, they need to expand their benefits to include a wider range of long-term care services. Presently, HMOs remain focused on acute and institutional services. Like other providers and insurers, HMOs have been reluctant to provide long-term care because of concerns with moral hazard and adverse selection. Yet, HMOs, or any other provider for that matter, cannot be viewed as a truly appropriate means of delivering care to the elderly until it includes a continuum of integrated medical and supportive services.

Of course, this brings us back to the major flaws within the Medicare and the Medicaid programs. In order for us to move toward a system in which managed care systems provide a full range of health and long-term care services to the elderly, significant changes must occur in current federal programs. This might incude: the consolidation of public programs designed to provide health and long-term care for the elderly.

Most significantly, this would suggest removing long-term care services from the Medicaid program and including them within the Medicare program. And it would also include consolidating Parts A and B. These long-term care services would be provided based on the beneficiaries' ability to pay.

Also provide higher capitation rate for managed care systems who choose to provide a full continuum of health and long-term care.

Continue the emphasis on enrollment of Medicare beneficiaries in managed care plans. One way to do this is to open the risk contracting option to other organizations besides HMOs and CMPs. InterStudy's June 1986 HMO census showed a total of 595 HMOs nationally. Even if all these HMOs choose to enter into risk contracts for Medicare beneficiaries, there would not be the capacity to enroll a large portion of this population.

The traditional Medicare fee-for-service delivery system has had several flaws. They include the lack of integration between acute and long-term care, a strong acute care bias, and the development of long-term care based on an acute care model.

Managed care systems have an opportunity to break away from these inappropriate biases to develop innovative, cost-effective, and appropriate care systems for the elderly.

Senator MITCHELL. Thank you very much, Miss Polich.

[The prepared written statement of Ms. Polich follows:]

TESTIMONY BEFORE THE SENATE FINANCE COMMITTEE
January 29, 1987

Cynthia Longseth Polich
Executive Vice President
InterStudy
Excelsior, Minnesota

Good Morning! My name is Cynthia Polich, Executive Vice President of InterStudy, a non-profit health care research organization located just outside Minneapolis, Minnesota. For over a decade, InterStudy has been involved in promoting and monitoring the development of managed care systems and capitation financing. In the past two years, we have spent considerable time examining the appropriateness of managed care systems and capitation for the Medicare population. I would like to concentrate my opening remarks on some of the key findings of our work in this area.

Not surprisingly, our research has shown that the current system of providing health care to the elderly is marred by at least two major flaws. First, it is excessively costly to both the public sector and Medicare beneficiaries. Second, the system is fragmented and biased toward acute care, even though the high prevalence of chronic conditions among the elderly creates a need for an integrated system that includes both acute and long-term care services. Given these major flaws, any reform of Medicare should be guided by two broad goals -- the integration of acute and long-term care into one package and the capitation of Medicare benefits to control costs.

For these reasons, we are very supportive of the federal government's current efforts to encourage Medicare enrollment in HMOs. We are also closely following the progress of the Social/HMO demonstration projects as a promising method to accomplish both the goals we have identified. We strongly believe that this is the direction that the Medicare program should head. But, it is also clear that several issues and problems with Medicare capitation must be resolved.

One of the keys to the success of Medicare capitation is the development of an appropriate methodology for determining the capitation rate. If the capitation rate does not adequately reflect the real costs incurred by HMOs, they may be significantly overpaid or underpaid for the services they provide to their enrollees. There is a great deal of evidence that the current use of the AAPCC is very inadequate -- only explaining approximately 1% of the variation in costs for Medicare beneficiaries in HMOs. Because of this, we strongly recommend that a new formula for determining the capitation level, preferably including some type of case mix adjustment, be developed soon.

Quality of care is another important issue that must be dealt with if Medicare risk contracting is to be successful in the long term. While it is generally agreed that capitation financing provides incentives to contain costs, some also suggest that capitation may result in inferior quality or underservice because of the strong focus on saving money. Clearly, much more needs to be done to develop adequate quality assurance mechanisms and to demonstrate that the care provided through managed care systems is of adequate quality.

Quality of care, however, has two components. It not only involves the question of whether the services provided are of high quality, but also whether the entire service package is appropriate and complete. For the elderly, this means that a wide range of coordinated acute and long-term care services must be provided. HMOs have the potential to improve the health and long-term care system for the elderly because they are designed to integrate a wide range of services and providers. For HMOs to achieve this potential, however, they need to expand their benefits to include a wider range of long-term care services. Presently, HMOs remain focused on acute and institutional services. Like other providers and insurers, HMOs have been reluctant to provide long-term care because of concerns with moral hazard and adverse selection. Yet, HMOs, or any other provider, cannot be viewed as a truly appropriate means of delivering care to the elderly until it includes a continuum of integrated medical and supportive services.

Of course, this brings us back to the major flaws within the Medicare and Medicaid programs. In order for us to move toward a system in which managed care systems provide a full range of health and long-term care services to the elderly, significant changes must occur in current federal programs. This might include:

> The consolidation of public programs designed to provide health and long-term care for the elderly.
>
> Most signficantly, this would suggest removing long-term care services from the Medicaid program and including them within the Medicare program. These long-term care services would be provided based on the beneficiaries' ability to pay.
>
> Provide a higher capitation rate for managed care systems who choose to provide a full continuum of health and long-term care. (However, we must acknowledge that there would be considerable concern regarding potential adverse selection if this were allowed.)
>
> Continue the emphasis on enrollment of Medicare beneficiaries in managed care plans. One way to do this is to open the risk contracting option to other organizations besides HMOs and CMPs. InterStudy's June 1986 HMO census showed a total of 595 HMOs nationally. Even if all these HMOs chose to enter into risk contracts for Medicare beneficiaries, there would not be the capacity to enroll a large proportion of this population. For this reason, we would support allowing other health care organizations and employers, for example, to enter into risk contracts for Medicare beneficiaries.

A final issue that should be considered regarding risk contracting is the legislatively mandated 50% cap on Medicare and Medicaid enrollment. While we acknowledge that the 50% rule was implemented to ensure quality within HMOs (assuming that if the HMO had a 50% commercial enrollment, it provided care of adequate quality), and the recent problems with the IMC waiver of the 50% rule have encouraged new and widespread support for this concept, we nonetheless question its appropriateness. One reason for the slow development of expanded and innovative geriatric programs within HMOs may stem from the 50% cap on Medicare enrollment. This can discourage HMOs from investing the time and money needed to develop plans specifically designed for older persons. It is widely acknowledged that the elderly possess unique health and long-term care needs. This may require the development of special geriatric care systems to adequately meet these needs. For this reason, it may not be appropriate to eliminate the potential of developing Medicare-only HMOs.

The traditional Medicare fee-for-service delivery system has had several flaws. They include the lack of integration between acute and long-term care, a strong acute care bias, the development of long-term care services on an acute care medical model, the inability to acknowledge the need for long-term care services as something other than a substitute for acute care services, and the development of a health care system for the elderly based upon the needs of younger individuals. Managed care systems have an opportunity to break away from these inappropriate biases to develop innovative, cost-effective, and appropriate care systems for the elderly. Adequate support and financing from the federal government, however, is the crucial factor which will determine whether this occurs.

Senator **Mitchell**. Professor Reinhardt.

STATEMENT OF PROFESSOR UWE REINHARDT, PRINCETON UNIVERSITY, WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS, PRINCETON, NJ

Professor **Reinhardt**. Thank you, Mr. Chairman, for inviting me to testify on the important problem of health care for the aged and the poor, and my apologies also to Senator Durenberger for the absence of my usually stimulating clout. In that absence, I feel ineffective like an Italian food vendor with his hands tied. But to overcome the frustration, I have added a hard copy of 12 such slides to my statement, and the thrust of those is to challenge a widely held myth and that is that lack of money is the source of our problems in the American health system.

My view is actually the system of Washington money, and America distinguishes itself by being wasteful and imprudent in the use of an abundance of resources.

Ever since the turn of this decade, one theme has dominated the health care conference circuit, which Senator Durenberger spoke of, and that is, the themes of it are health care in an age of contracting resources. I find this theme humorous. If you repeat it often enough you will begin to believe it. But as an egghead—academic, that is to say—it is my role to question prevailing folklore and that is what I do.

What do we mean by "resources in health care"? There are really three distinct types. One is the real resources: doctors, hospital beds, nurses. They are entering the health field to do good and possibly well by doing good.

Secondly, the money that flows into the sector to support these, to make sure that these people who do good do well. And that is financial resource, to distinguish from the real resource, which are the people.

And then, finally, the real service is going from these providers to the patient. If there had been a contraction in American health it has been in the latter component only. There has been a decrease in physician visit, quite substantially in the last four years, and a decrease in hospital base, quite substantial. So, yes, there has been a contraction of health services flowing from provider to the patient.

But what is the cause of this? Is it a lack of real resources? Is it a lack of money? I ask myself. It cannot be a lack of real resources. Why else would organized medicine complain about a physician surplus and everyone else? Why would we have occupancy ratios of 60 percent in American hospitals? There is no shortage of real resources.

Is it a shortage of money? That is the next question? And for that question the unambiguous answer is yes and no. [Laughter.] Let me begin with a note.

Senator **Mitchell**. You could be a Senator, Professor Reinhardt. [Laughter.]

Professor **Reinhardt**. I am learning.

If you look at figures 1 and 2, and later on, figures 9 and 10, on Medicare, it is hard to read into these figures a drastic reduction in the flow of money to health care. You read this daily in the paper that there have been Medicare cuts, another $5 billion. But these cuts are imaginary cuts off an imaginary trend line, and between an imaginary trend line and an imaginary Presidential budget. That is all they are. The real hard facts is what was spent. And I invite you to look at it. We are spending plenty, more than any other nation on earth.

So the challenge to American health care providers collectively is surely this question. We have a surplus of beds, a surplus of doctors. We spend more than any other nation on earth. What is it that the American people get in return for this largesse that other nations do not get, say, like Canada? We spend 10.7 percent of the GNP on health care; they, 8.5 percent. What is it we get that the Canadians don't get? And I would ask also, what are they getting that we do not get? For example, peace of mind is no problem with indigent care. In Canada, there are no such conferences; they do not have those problems. So that is the challenge. So that is the no answer. There is plenty of money in the system.

Yes, there is a shortage of money in certain spots within the system. World areas are not adequately funded. Urban municipal hospitals are being starved.

Karen Davis spoke eloquently on Medicaid. Figure 6 shows it has grown much less rapidly; allocations to it. And I would say this country is sorely neglecting certain segments of the impoverished baby boom. That is a mortgage our children will have to pay one day when the children of those baby boomers are sick and ill-educated, one of the many mortgages we are riding.

So our problem is not one of economics or budget. It is one of sharing equitably an abundance of health care resources.

I have several proposals briefly alluded to in this paper on Medicare for the aged. The aged voted, like everyone else, for politicians who honestly said we will cut taxes, raise Defense expenditures, and cut social spending. That is what they put out; the aged voted for it. With that, comes a certain noblesse oblige, that is, to share in the sacrifice.

I think the time is at hand to ask the aged to practice noblesse oblige among themselves. One vehicle for doing that might be Karen Davis and Diane Roland's proposal to fuse Part A and B of Medicare, and to have the aged contribute a premium that is income-related. That means you would siphon resources from well to do aged, of which there are many, and recycle them to the poor aged, whose cost sharing now is a burden that the civilized society should not visit upon its aged. That would be one proposal. And I have others that I am glad to talk about for the uninsured.

Senator MITCHELL. I am certain we will ask you about the others, Doctor, when we get to the question—Professor, when we get to the question as heard.

[The prepared written statement of Professor Reinhardt follows:]

STATEMENT BY

UWE E. REINHARDT, PH.D.
JAMES MADISON PROFESSOR OF POLITICAL ECONOMY
PRINCETON UNIVERSITY

The American health sector currently finds itself in a perplexing situation, one few foreigners would be able to grasp. The nation is clearly beset by a surplus of hospital beds. Organized medicine is clearly exercised over an alleged surplus of physicians, and many experts agree that this assessment is correct. We are devoting a larger slice of our Gross National Product to health care than ever before in our history, or than is spent by any other nation on its health-care sector. Yet the health-care conference circuit, and these hallowed halls, forever buzz with the sobering theme: "Health Care in an Age of Contracting Resources." And, as if to underscore its dire straits, our health sector now produces with troublesome regularity stories of fiscal hardship befalling poor and sick Americans, and even of outright denials of critically needed care just because patients are poor and uninsured. These circumstances tax the notion that ours is the best health care system in the world. To achieve so much anxiety, so much turbulence and so much fiscal hardship with a sector so richly endowed with real and financial resources cannot be a source of national pride.

Attached overleaf are a number of graphical displays on recent trends in health care revenues. (In health care, the term "revenues" can be used interchangeably with "expenditures" because one person's expenditures is another's revenue). These displays are meant to challenge the widely publicized assertion that the growth of health-care revenues (expenditures) in this country has been tightly controlled, and that the Medicare and Medicaid budgets, in particular, have been brutally slashed year after year during the first half of this decade. The budget cuts alluded to by the providers of health care, and by the media, usually have been the imaginary differences between some imaginary trend line that would obtain under a "business as usual" posture and the equally imaginary trend lines incorporated in the President's annual budgets. Even the President's own allegedly tight budget, for example, calls for Medicare outlays in the neighborhood of $ 100 billion by the end of the decade, up from the $ 37 billion or so spent in 1980s. The 1980s may be remembered for much budgetary mischief, but a decimation of the Medicare program will surely not be part of that mischief.

Let me state at the outset that I am not one who can bring himself to view the growth of total national health expenditures, or even the growth of Federal outlays on health, as a serious problem. Ours is a wealthy and relatively undertaxed nation, and one whose President not long ago openly took credit for having allocated some $ 30 billion or so per year to an agricultural support program known to favor rich landowners[1]. A nation content to shower so generous a monetary benificence on wealthy landowners as a reward for not growing food, or for growing unwanted food, ought not to lose too much sleep over possibly wasting a dollar here and there on health care, possibly providing a free physician visit or hospital day to an "undeserving" near poor, or possibly overpaying this or that health professional.

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[1] See The New York Times, August 13, 1985.

Thus my point in submitting to you the graphical displays on health care expenditures (revenues) is not meant as an urgent plea to constrain the growth of this money flow. I submit them here merely to blunt the thrust of the much mouthed theme that the difficulty our society has in protecting low income households--young and old--from illness-induced fiscal hardship is a consequence of an overall shrinkage of health-care resources. That theme is a myth pure and simple. *Our problem in this respect is not strictly an economic one, nor even a budgetary one : it is merely our inability to share equitably real and financial health-care resources that have flown to the health sector in abundance*. The problem before this body in the next few years will be to help devise ways in which that abundance can be more sensibly and equitably shared.

To explore this task further we might consider, for example, the peculiarly skewed Medicare program. That program is now overly generous to well-to-do aged (many of whom dispose of a sizeable stock of assets) and it is much too parsimonious vis-a-vis the low-income aged whose out-of-pocket expenditures for health care represent a troublesome tax on their already meager disposable income.

The argument could, of course, be made that *all* members of the now retired generations who suffered the Great Depression, bravely and successfully fought World War II, and subsequently educated quite generously the Baby Boom, could fairly expect to have their health care paid by the now working generations without the indignities of means testing or cost sharing at point of service. I have, in the past, openly defended this view, in the secure knowledge that, because other industrialized societies (e.g., Canada, France and West Germany) can do this, the United States could do it as well.

To pursue that noble policy under honest governance, however, clearly would require adequate taxation. But, to the best of my knowledge, our aged voted in recent years with marked enthusiasm for candidates promising reduced taxation, lean budgets for social programs and high defense outlays. Having registered their preferences in this respect at the ballot box, the aged could have been expected to share willingly in the fiscal sacrifices they have advocated with their votes. Not to do so, that is, to insist that the Medicare and the Social Security programs be left completely untouched by the desired fiscal austerity, actually amounts to the statement that whatever fiscal sacrifice is to be borne should be cut out of the lives of low-income Baby Boomers, of which there are, unfortunately, millions and of whom millions are completely without any health insurance coverage whatosoever. Surely one may question the social ethics implicit in this political posture.

The implication of the preceding remarks is that the time may well be at hand to invite the nation's well-to-do aged to exercise some *noblesse oblige*, first, within their own ranks, and second, vis-a-vis poor Baby Boomers as well. One move in this direction would be implementation of a proposal first offered by my colleagues Karen Davis and Diane Rowland[3]. Under that proposal, the now separate parts A and B of Medicare would be fused into one, and the aged would be asked to pay an income-related premium for the privilege of the combined package. The added funds thereby extracted from upper-income aged could be used to relieve the low income aged from the now heavy degree of cost sharing that now constitutes an intolerable percentage of their disposable income.

At some point soon Congress ought also to explore ways to make a revised version of the Medicaid program automatically available to any American who is not otherwise insured for health services. The premium for such a program could, once again, be income-related at rates calibrated so that the bulk of middle- and upper-income Americans would prefer private health insurance coverage. The additional general revenues required by that approach could be procured from a variety of sources, among them further taxation of cigarettes, taxation of gasoline and, possibly, taxation of certain fringe benefits now exlcuded from taxable income. Time and space limitation preclude me from offering more detail on this proposal. It has been spelled out at greater length in testimony before the House Select Committee on Aging, and in a paper forthcoming in Health Affairs (Spring, 1987).

Finally, it may be possible to achieve some further savings in the prices Medicare pays for health services, which implies in many instances to reduce the hourly income earned by heaslth professionals from the process of health care. As one who has observed the formation of health policy in this country for close to two decades now, however, I am skeptical that significant further program savings can be had in this way, aside from some constraint on price increases that might obtain without further reimbursement reform. A test of my hypothesis will be furnished by the reaction of Congress to reimbursement reforms recently proposed by the Office of Management and Budget.

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[3] Karen Davis and Diane Rowland, "Medicare Financing Reform: A New Medicare Premium,"Milbank Memorial Fund Quarterly Health and Society, vol.62, No.2, Spring, 1984; pp.300-16.

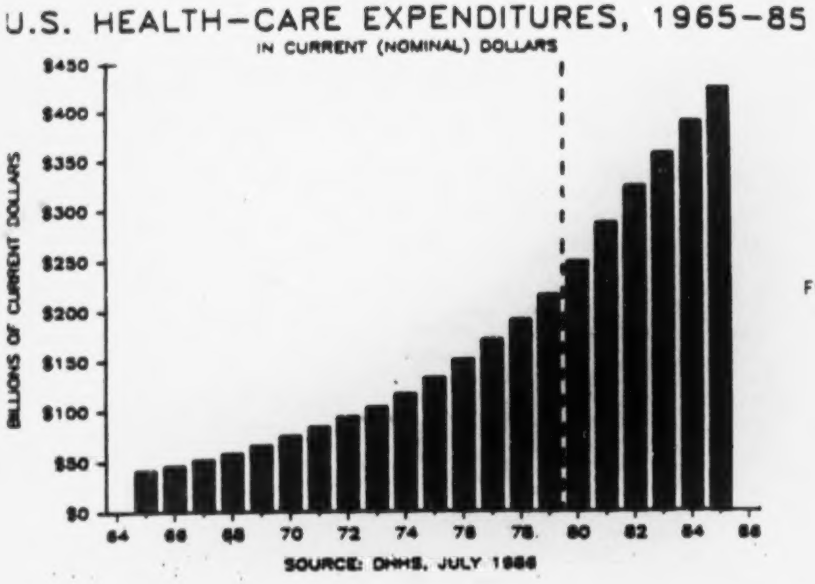
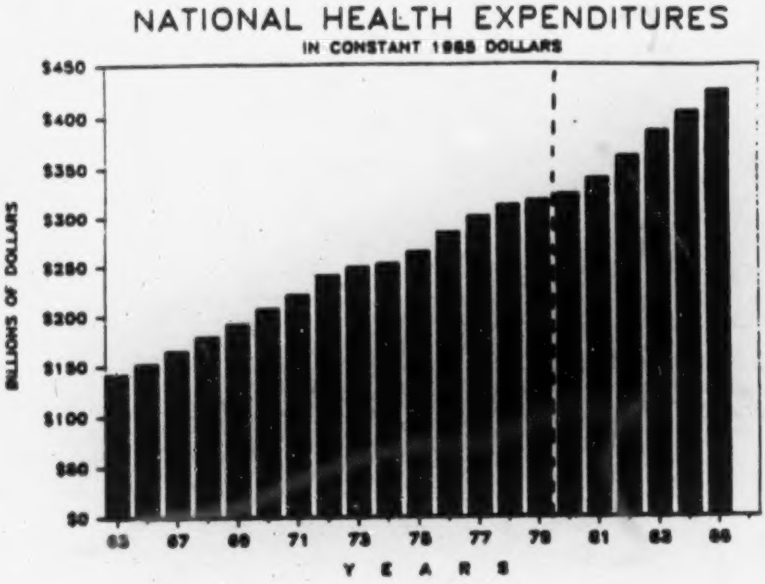


Figure 1



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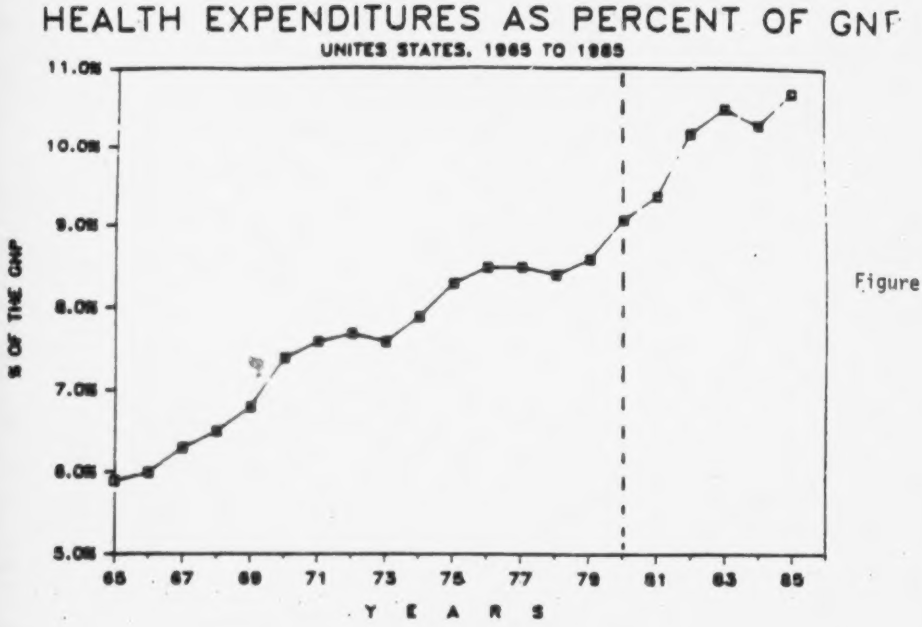
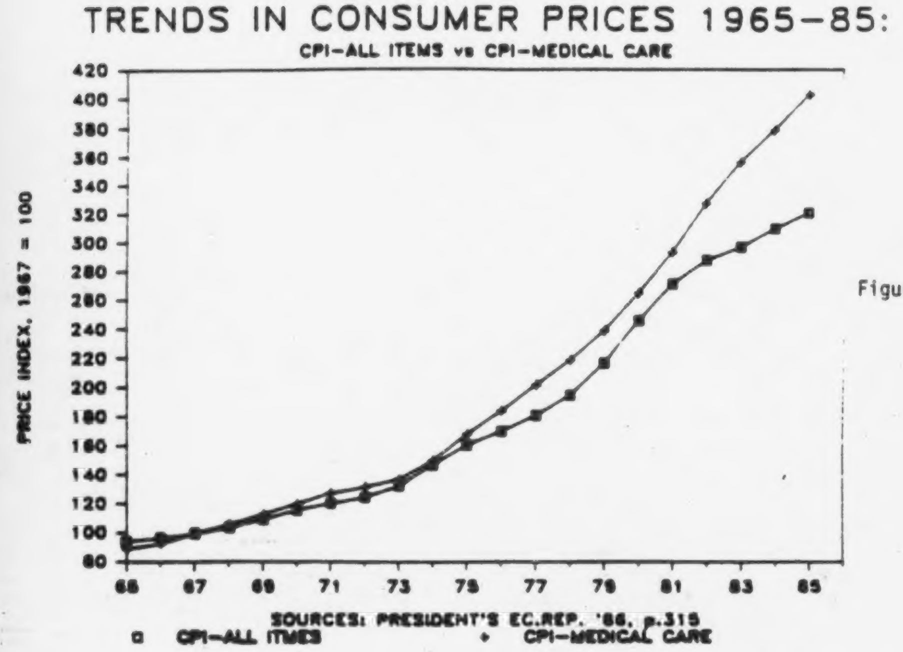


HEALTH EXPENDITURES AS PERCENT OF GNP

UNITES STATES, 1965 TO 1985

Figure 3



TRENDS IN CONSUMER PRICES 1965–85:

CPI–ALL ITEMS vs CPI–MEDICAL CARE

SOURCES: PRESIDENT'S EC.REP. '86, p.315

Figure 4

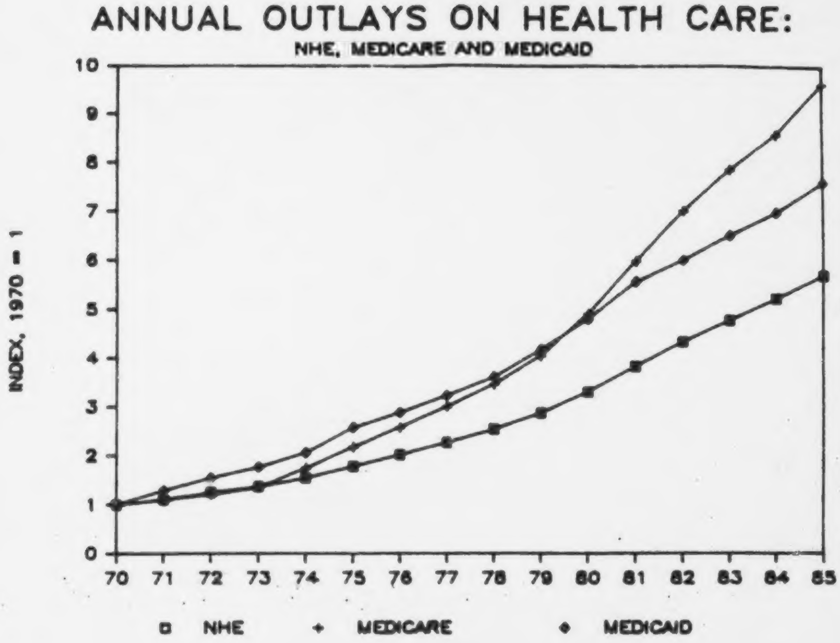


Figure 5

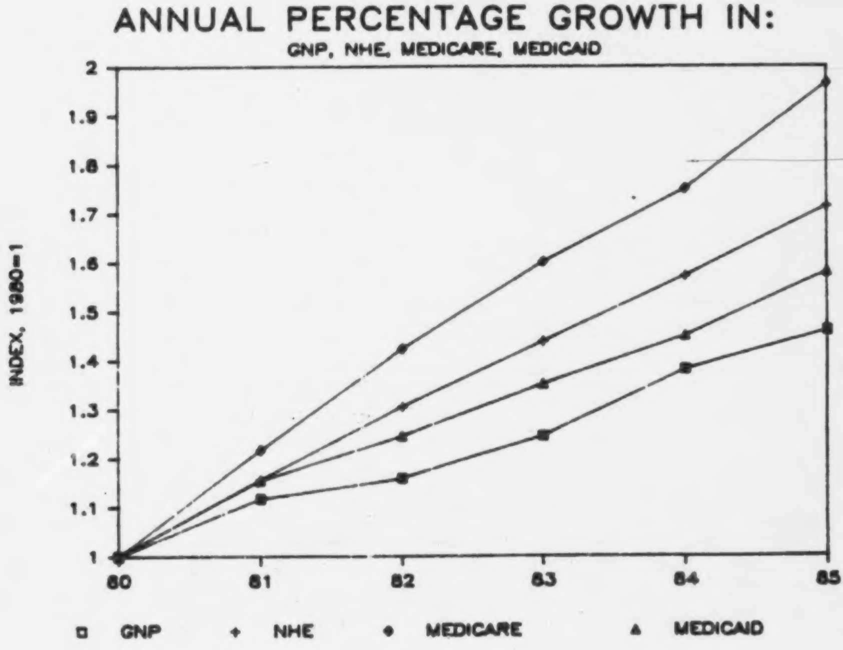


Figure 6

ANNUAL OUTLAYS ON MEDICARE, MEDICAID
IN CURRENT DOLLARS

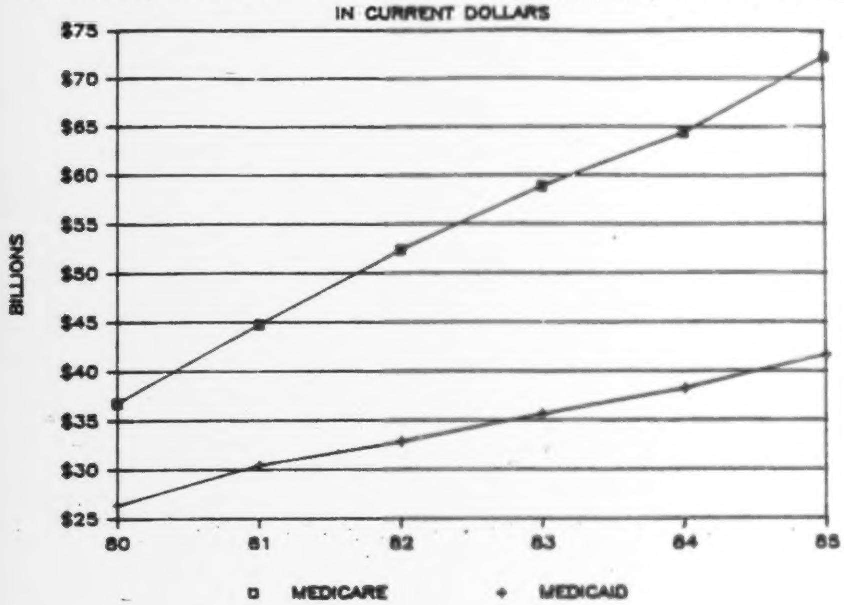


Figure 7

ANNUAL OUTLAYS FOR MEDICARE
IN CURRENT DOLLARS

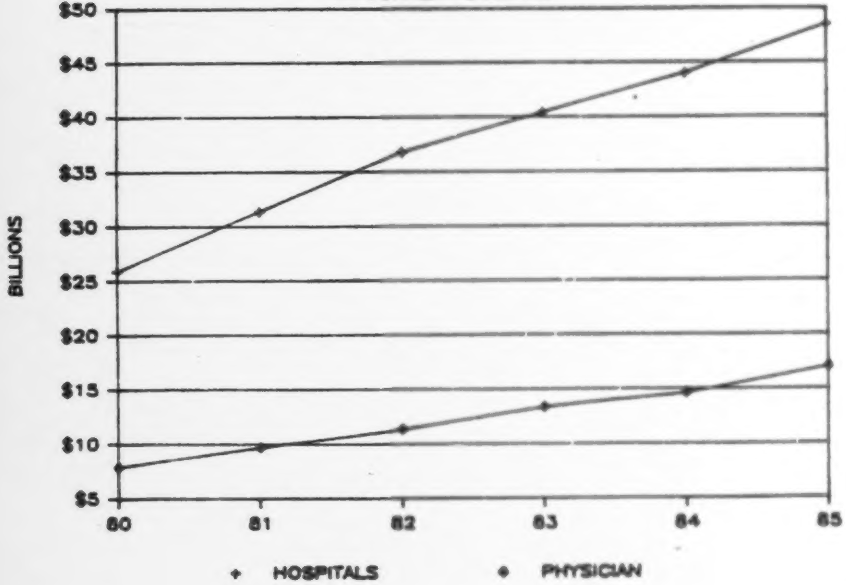


Figure 8

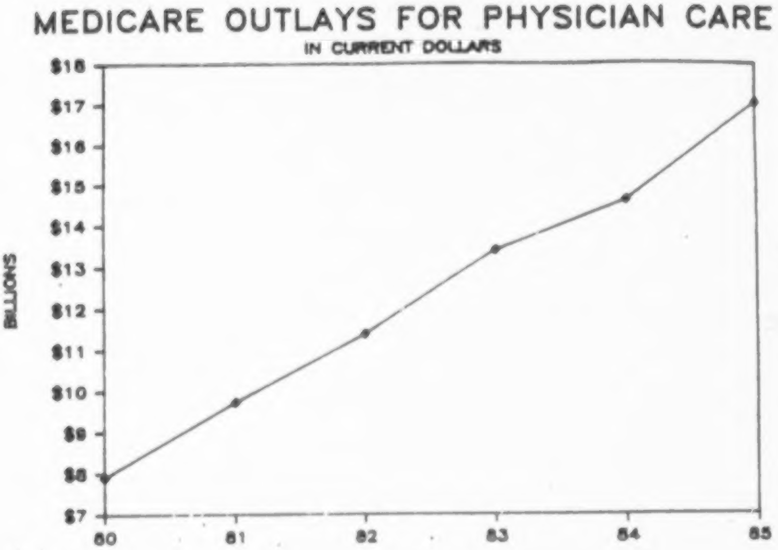


Figure 9

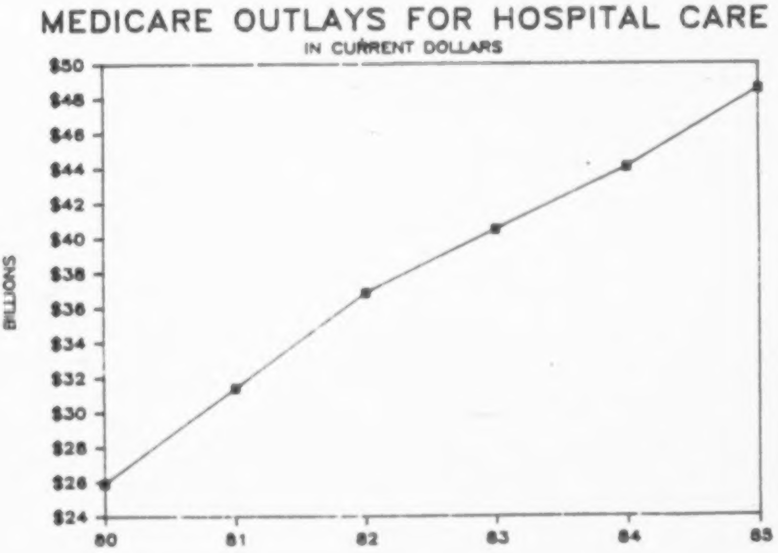


Figure 10

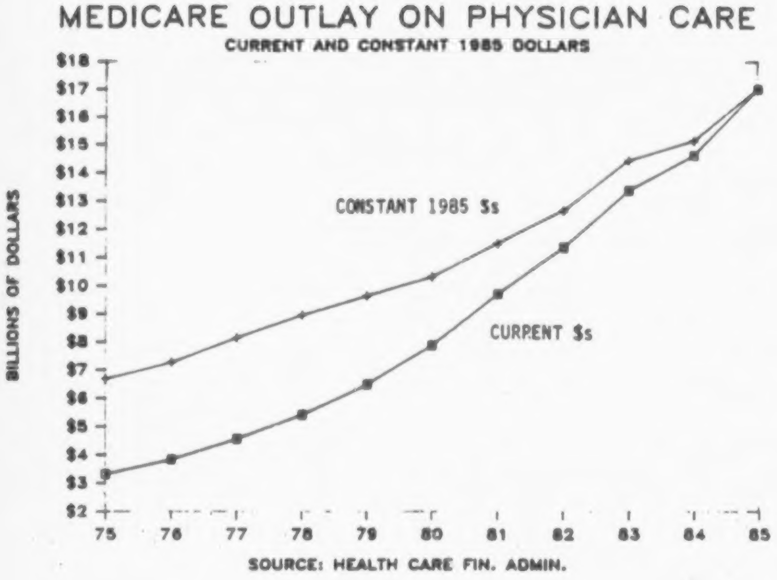


Figure 11

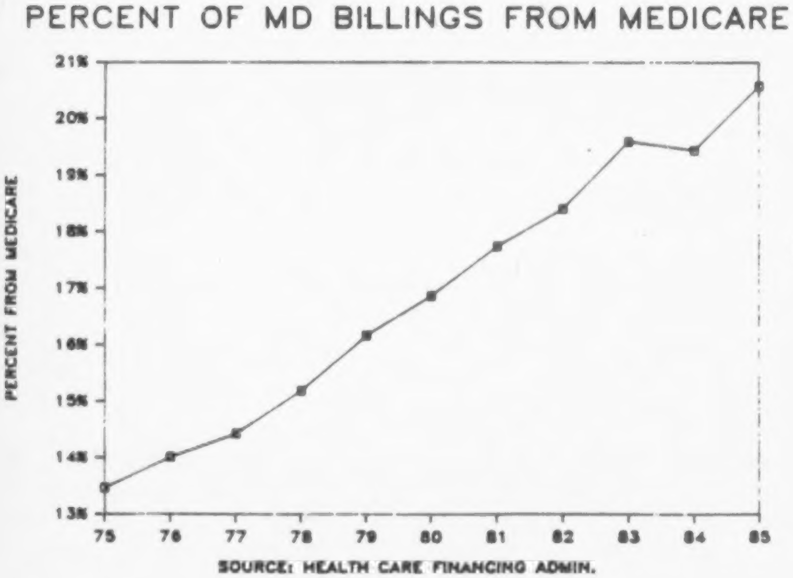


Figure 12

Senator MITCHELL. Dr. Rubin.

STATEMENT OF ROBERT RUBIN, M.D., ICF, INC., WASHINGTON, DC

Dr. RUBIN. Thank you very much.

Under the truth in testifying rules here, I believe it is useful to identify myself as being the only physician on the panel. Consequently I will talk a little bit about physician payment. Since I was also an Assistant Secretary in this Administration, and the former chairman of the intra-departmental task force on the design, passage and implementation of something called the prospective payment system, I will also comment on PPS.

The question that we were asked to address was whether or not the Medicare budget reductions, particularly since 1983. have affected the quality of care for the Medicare beneficiaries. As Dean Altman and others have said, I believe unequivocally that there has been no wholesale decline in the quality of care. Is there any hard data for this? Not really. However, if only 1 percent of the 10 million discharges in this country had resulted in poor quality of care, there would be 100,000 people complaining, not to mention their families, loved ones, and certainly their elected representatives.

I would like to point out, however, that, as Senator Mitchell said in his opening statement, there is absolutely no question that people are being discharged sooner from the hospital than previously, and that they need more complex after care. So what we are seeing is an attempt to provide care at the appropriate level of sophistication in an effort to be cost effective. That is not bad; it is merely different from what we are used to.

I think that there are several issues that we need to be concerned about relative to the quality of care that Medicare beneficiaries receive. Others have talked about update factors and capital payments. In the limited time I have available I would like to focus on those issues that have not been addressed.

Regarding medical education, the fundamental question is whether or not the federal government should contribute towards the training of interns, residents, nurses and allied health professionals.

In the past, the answer has been yes, and the government has contributed its share. Now in the abstract, it is certainly a legitimate question of public policy as to whether or not the government or any other payer should subsidize the postgraduate training of our nation's health professionals. However, it is important to remember that while education is an important part of postgraduate training, the nation's 75,000 residents do provide a great deal of patient care, particularly in inner-city hospitals.

Assuming that they will not work for free, an assumption which this week's Newsweek Magazine suggest is wrong, as apparently 200 residents do work for free, the hospitals will either have to bear the cost, shift the cost—and I wonder to whom—replace them—I wonder if at higher cost—or change the mix of services the hospital provides. All of these choices may well undermine the quality of care given at our teaching hospitals, especially the largest and best, which are generally located in the inner-cities and treat an older and poorer patient population.

I, therefore, suggest that before any action is taken in this regard, we ought to take a look at potential long run problems relative to quality of care.

The second thing I would like to talk about just briefly is to say that the indirect medical education adjustment is again under attack. As members of this committee are well aware, the indirect medical education adjustment had absolutely nothing to do with medical education when it was first proposed by the Congress, but was a recognition that teaching hospitals took care of sicker patients, and that there is currently no way to adequately deal with the intra-DRG's severity of illness issue. Increasing indirect medical education payments was a proposal that was made by the Congress and readily accepted by the Administration. I believe we ought to be very careful before we cut that, particularly by 50 percent.

As far as physician payments are concerned, as you know, the Administration proposes to use DRGs to pay radiologists, anesthesiologists and pathologists. While there are no specifics on this plan that I am aware of, I believe this proposal is both ill-conceived and could potentially have adverse effects on patient care.

Prior to instituting hospital DRGs, Medicare had over 15 years of hospital cost data. At the present time, HCFA has no cost data on physician services. The success of PPS was clearly based on the law of averages, yet even an unsophisticated observer of the medical scene would recognize that physicians frequently have a nonrandom distribution of patients.

For example, as a Board-certified nephrologist in an academic teaching institution, I see a very different kind of patient than my community hospital colleagues.

I think it is important to point out that the current financial incentives to physicians are exactly the opposite of those of hospitals. This allows the physician to act as the patient's advocate, a position that would be very difficult under a DRG system which included the physician.

Moving quickly to Medicaid, I believe that the critical public policy issue regarding Medicaid is whether or not we wish to maintain the Medicaid program in its current form. Both Senator Moynihan and Senator Evans have proposed a uniform national standard for AFDC, and therefore, Medicaid, and I believe that this deserve serious consideration, as well as finding financing vehicles for them.

In conclusion, I think that there are some things that the Administration proposed that are good. I believe for example, that the increase in the Part B premium is important and should be done. I would suggest, as others have, that it be income-related rather than just across the board.

Thank you.

Senator MITCHELL. Thank you, Dr. Rubin.

[The prepared written statement of Dr. Rubin follows:]

TESTIMONY

OF

ROBERT J. RUBIN, M.D.

Mr. Chairman, my name is Robert J. Rubin. I am currently the Executive Vice President for Health Affairs at ICF Incorporated, a Washington, D.C. based consulting firm. In addition, I am a clinical associate professor of medicine at the Georgetown University School of Medicine. From 1981 until April 1984, I was the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services (HHS). In that capacity, I served as chairman of the intra-departmental task force responsible for the design and implementation of Medicare's prospective payment system (PPS).

My task today is to comment on Medicare and Medicaid and attempt to answer the question of whether the budgets of these programs have been cut too much, resulting in diminution of the quality of care or access to care afforded beneficiaries of these programs. In addition, I have been asked to suggest what, if any, further reductions can be made in these programs without adversely affecting their beneficiaries. Framing the questions as I have allows me to answer without regard to the very real concerns both Administration and Congressional decision makers must face in making their own budgetary decisions. I will not therefore consider such things as the effect the Gramm-Rudman-Hollings law might have had or possible "trade-offs" between the HHS budget and that of the Department of Defense, both of which probably did play a major role in federal budget decisions.

OVERVIEW

To better understand where we are, it is useful to remember where we were in 1981. As we entered the eighties, Medicare budgets were growing at about 20 percent per year, with hospital costs representing the major piece of Medicare's budget. Since its inception, Medicare had paid hospitals on a cost basis. Simply put, that meant that for every dollar spent, a hospital received a dollar back (subject, of course, to Medicare rules). More importantly though, it also meant that every dollar a hospital **saved** was a dollar **less** in revenues. Clearly then, there was no incentive to save.

Thus, the spiralling of hospital costs was hardly surprising. The first temporary step to reduce the rate of growth of hospital expenditures was the Tax Equity and Fiscal Responsibility Act (TEFRA). This law allowed hospitals to keep part of the savings they could achieve. In addition, TEFRA required the Secretary of HHS to report to Congress by December 1982 on how to pay hospitals prospectively.

Our report recommended the institution of a prospective payment system for Medicare inpatient expenditures using a methodology called Diagnosis Related Groups (DRGs). This system was designed at Yale University, used in New Jersey and modified at HHS for use in Medicare. It was designed to pay a hospital the costs of caring for patients based on their diagnosis. PPS is a system based on averages. It assumes that a hospital will have some patients that cost more, and some that cost less than the DRG price. It was introduced in the Congress in early 1983 and signed into law by President Reagan in April 1983. It became effective on October 1, 1983.

Some important principles of the original PPS statute are worth recalling. First, the program was for a period of time to be budget neutral. Second, each year the payment was to increase by the increase in the costs of hospital inputs (the "market basket") plus one percent for technologic improvements in patient care. Third, because DRGs do not measure the intensity of services provided to patients and because some hospitals do not have a random distribution of patients, it was decided to pay an additional amount to hospitals with sicker patients. The Congress, with the support of HHS, did this by assuming that teaching hospitals generally take care of sicker patients and doubled the add-on given for the indirect costs of medical education. Let me be clear; this add-on never had anything directly to do with teaching. It was simply a device to make DRG payments equitable. With these principles in mind, PPS was hailed by hospitals, the media, and most of the public as an innovative and equitable solution to Medicare's uncontrollable growth.

The honeymoon was short-lived. PPS did, however, achieve most, if not all, of its original goals. Average length of stay declined from 10.4 days in 1981 to 8.8 days in 1985. Medicare expenditures grew 8.6 percent from 1983 to 1984 but only 5.5 percent from 1984 to 1985. In addition, for the first time since World War II hospital employment declined 2.3 percent between 1984 and 1985 . Inpatient admissions for Medicare beneficiaries declined 1.7 percent.

Changes adopted subsequent to the enactment of PPS, however, may jeopardize hospital profitability, and therefore affect quality of care. A study conducted by ICF in 1986 indicates that if the policy in effect at that time were to have continued, hospital profits would have been eroded. While it is true that some hospitals increased their profitability initially under PPS, these gains have been diminished by subsequent changes in Medicare PPS policy. Our study indicated that at least 59 percent of the nation's hospitals could fail to earn a profit in 1986.

MEDICARE

THE PAST

Have the Medicare budget reductions particularly since 1983 affected the quality of care afforded Medicare beneficiaries? Unequivocally, there has been no wholesale decline in the quality of care. I say this based more on common sense rather than any hard data. There are roughly 10 million Medicare discharges annually. If only 1 percent of them believed that their care was seriously compromised, that would result in at least 100,000 people complaining--not to mention their families. While there have undoubtably been some abuses and misunderstandings, I believe at the present time that PRO's and the provider community as a whole are doing a good job. I would like to point out that there is no question that people are being discharged sooner from the hospital than previously and may even need more complex aftercare but what we are seeing is an attempt to provide care at the appropriate level of sophistication in an effort to be cost-effective. This is not bad, merely different from what we have previously been used to.

THE FUTURE-QUALITY OF CARE

The future, however, may not be so bright. I am concerned about three aspects of the administrations budget that may directly affect the quality of care in the future. They are:

- Update Factor
- Capital Payments
- Medical Education Payments

UPDATE FACTOR

The Congress in the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) set the rate of increase for hospital payments at the market basket minus 2 percent. Simply put this means hospitals will receive 2 percentage points less than the increase in what they need to provide patient care. An example of how this has worked is found in Exhibit 1. Consider such a hypothetical hospital located in Region IV. The table summarizes payment amounts using the appropriate blending factors, and assuming that the wage index is equal to

EXHIBIT 1

HYPOTHETICAL HOSPITAL EXAMPLE[1]
(Region IV)

	FY84	FY87
Federal Regional Rate	3,021	3,174
Federal National Rate	--	2,984
Hospital Specific Rate	3,021	3,221
Payment Rate	3,021	3,114
Hospital Costs	3,021	3,493
Difference Between Costs and Rate	0	-$379

[1]- To simplify the analysis, and to isolate the effect of changes in the Federal rates, an appropriate hypothetical case would be a hospital that:

- In 1984, the PPS base year, had a fiscal year matching the Federal fiscal year and a computed adjusted standardized amount (ASA) exactly equal to the Federal regional rate for its region, adjusted for case mix.
- Is neither a teaching hospital or a hospital that might subsequently qualify for payments as a disproportionate share hospital;
- Experienced increases in its actual costs under Medicare equal to the base year ASA increased by the national market basket, and
- Being located in an urban area, was least affected by the reallocation in area-specific wage indices resulting from recomputation of the rural wage indices.

1.0. Application of the update factor, because it has not kept pace with the market basket, results in a substantial shortfall for this hospital. The theory here is that hospitals will make up the difference from their "profits" or "excess revenues". The only problem with that theory is that many hospitals will not have "excess revenues" to draw upon. Indeed my company, ICF Incorporated, estimates that of all the hospitals currently under PPS, roughly 59 percent have operating margins less than 1.0 and 48 percent have total margins less than 1.0. Even so, the administration proposes an update factor of 1.5 percent for a savings of $510 million.

I believe that HHS and HCFA are genuinely concerned about the process used to generate the update factor and perhaps the report that they will send the Congress on April 1 along with the annual PROPAC report will indicate they have reformed their process sufficiently to produce update factors that can be taken seriously.

CAPITAL PAYMENTS

The budget proposes to incorporate capital into the DRG payment. There is proposed to be a 10 year phase-in for fixed plant expenses and a 2 year phase-in for moveable equipment. Capital payments are to be "budget neutral" with respect to OBRA-1986 i.e. 7 percent reduction in 1988 and 10 percent in 1989.

In principle I agree with the policy of incorporating capital and operating payments into a single payment. I am, however, concerned about two potential problems. First, in FY88 we will go to national rates which will have some distributional effects on hospital payments. Second, if Medicare admissions fall in FY88 relative to FY87, Medicare capital payments will decline. While I have no problem linking future capital payments to future capital investments, I am concerned about hospitals that made capital expenditures approved and in some cases encouraged by federally supported entities, which now find that they cannot meet their capital obligations because of the change in Medicare's payment policy. The committee may wish to review this problem and treat "old" capital somewhat differently from "new" capital expenditures. A serious question that should be evaluated is whether restricting capital payments to 90 cents on the dollar will have a deleterious effect on hospitals acquiring new technology so that Medicare beneficiaries can continue to receive first rate care.

MEDICAL EDUCATION PAYMENTS

The fundamental question is whether the federal government should contribute towards the training of interns, residents, nurses and allied health professionals. In the past the answer has been yes and the government has contributed in the form of direct medical education payments proportional to the number of patient days used by Medicare beneficiaries. Recently, both the Administration and the Congress have proposed methods to reduce direct medical education payments. Some of the proposals while designed to save money also had other health policy goals in mind. For example, limiting the number of years the Government would provide full funding for interns and residents was an attempt to increase the number of those choosing primary care specialties. The current proposal would limit direct medical education payments for nurses and allied health professionals as well as classroom and other educational costs. This would save $310 million in 1988. In addition, the administration seeks repeal of the COBRA prohibition against further limits on direct medical education costs.

In the abstract, it is certainly a legitimate question of public policy as to whether or not the government or any other payor should subsidize the post-graduate training of the nation's health professionals. However, it is well to remember that while education is an important part of post-graduate training, the nation's 75,000 residents do provide a great deal of patient care. Assuming that they will not work free (a recent Newsweek article reported that currently 200 do-January 26, 1987 p. 57) the hospitals will either have to bear the cost, shift the cost (to whom?), replace them (at higher cost?) or change the service mix a hospital provides. All of these choices may well undermine the quality of care given in our teaching hospitals especially the largest and best which are generally located in the inner cities and treat an older and poorer patient population. I would, therefore, counsel both the Congress and the Administration against precipitous action.

The indirect medical education payment was designed before PPS to compensate teaching hospitals for the higher costs associated with teaching that were not direct costs. As I have stated earlier it was doubled somewhat arbitrarily in recognition that teaching hospitals took care of sicker patients and that the PPS system has no good way to measure intra-DRG severity of illness. Under COBRA this factor was reduced to 8.1 percent to account for the disproportionate share payments. The Administration proposes to save $835 million in FY88 by cutting the indirect medical education payment factor in half to 4.05. This is characterized as eliminating the "windfall payments" to teaching hospitals. In my judgement, it is inappropriate and does not recognize the original purpose behind this adjustment.

PHYSICIAN PAYMENTS

Among the most controversial proposals in the Administration's budget is the plan to pay radiologists, anesthesiologists, and pathologists (RAPs) using a DRG methodology. While there are no specifics on the plan that I am aware of, I believe that this proposal is ill-conceived and could potentially have adverse effects on patient care. Prior to instituting hospital DRGs, Medicare had over 15 years of hospital cost data. At the present time HCFA has **no cost** data on physician services. It does have charge and payment data from its 52 carriers, however, these vary widely not only among carriers but within carrier regions. In addition, the success of PPS with hospitals was predicated on the law of averages, yet even an unsophisticated observer of the medical scene would recognize that physicians frequently have a non-random distribution of patients. For example, as a board-certified nephrologist at an academic teaching institution, I would expect to see a different type of patient than a nephrologist at a community hospital or an internist.

Even if HCFA could somehow determine a fair price to pay RAPs, to whom would they make the payment? One of the important safeguards build into PPS was that the physician had a set of financial incentives designed to foster his role as patient advocate. By making the financial incentives of the hospital and the physician the same, I am concerned that the patient may be the loser. Will the radiologist recommend the extra study, the pathologist an extra examination of the specimen-I would hope so, but I am less than fully confident that this would occur uniformly.

Many of the remainder of the proposed physician payment reforms are only vaguely described in HHS budget documents, therefore, I cannot comment on them. In general, I would support changes that make physician payments more uniform nationally while recognizing legitimate differences in the cost of doing business (e.g. rents in New York are greater than those in Waterville, ME). In addition, the disparity between doing something to patients (procedures) and so-called cognitive services should be redressed.

CAPITATION

The leadership at HHS is committed to expanding the capitated portion of the Medicare program. The FY88 budget contains suggestions that HHS wants to include employer-based plans in the capitation option. While I generally support voluntary participation in these types of plans, I an uncertain of their appeal to a large number of beneficiaries and providers. The sine qua non for widespread success is that providers believe that they are going to be paid a fair price for the risks they are assuming. A corollary proposition is that beneficiaries believe that they will be no worse off under the new arrangement that they currently are under traditional Medicare. While I firmly believe that the current HCFA leadership subscribes to the above principles, past government action, for example with the PPS update factor, suggests cautious optimism at best.

Much of the above discussion has been critical of the proposed budget. I would like to applaud some proposals that should be passed and could achieve either savings or increased revenues. These proposals are:

- Increase the Part B premium to 35 percent for new enrollers and 50 percent for third party payors
- Index the Part B deductible to the Medicare Economic Index
- Include State and Local Employees under Medicare

The Part B premium was originally set by Congress at 50 percent of program costs. Recently, the Congress allowed it to rise to 25 percent since it had eroded between 1965 and 1983 to below 25 percent. The current administration proposal is a modest one and would only affect new enrollees and third party payors. A bolder approach would be to increase the premium for everyone to 35 percent but adjust it for income. This would be more equitable and probably raise more money than the administration proposal.

The Medicare Part B deductible was set at $50 in 1965. After about twenty years it was increased to $75 after it had eroded in constant dollars by more than half ($22). The principle of a deductible as a means of deterring unnecessary utilization is well established. The Congress should ensure the real dollar value of this deductible through indexing.

MEDICAID

The critical public policy issue regarding Medicaid is whether or not we wish to maintain the Medicaid program in its current form. Currently, eligibility for Medicaid is tied to eligibility to welfare (Aid to Families with Dependent Children-AFDC) and Supplemental Security Income (SSI). The eligibility levels for AFDC are set by the states and vary widely. In addition, states may cover those who would be eligible for AFDC or SSI except that they do not meet the income standards. This is the "medically needy" program. There have been proposals by Senator Evans and indirectly by Senator Moynihan to develop a uniform national standard for AFDC and therefore Medicaid. This would be extremely costly although Senator Evan's program has a financing vehicle; namely assumption of other categorical programs by the states. In my judgement, the imposition of national standards is the fundamental issue that must be decided if we are to have an equitable Medicaid program.

In contrast the FY88 budget proposal has several mechanisms to control the costs of the Medicaid program. Most of these proposals are not new and are designed to save money rather than effect policy changes. Among the new proposals the most interesting are:

- Capitation
- Infant Mortality Initiative
- Reimbursement Limit on Non Emergency Care in Emergency Rooms

CAPITATION

As an inducement to states to adopt capitation systems, the federal matching rate (FMR) would be increased 3 points the first year declining to the normal FMR in year four. HHS budget documents do not make clear whether the increased FMR would apply to **all** Medicaid payments or just those of the capitated program. Further, it is not clear how the increased FMR is integrated into the overall Medicaid cap. Finally, I could not find a cost (or savings) associated with this program. I would imagine that HHS is assuming that the increased FMR is matched by program reductions as a result of capitation. Again, the critical issues for a capitated program are what is the capitated price, who sets it, what are beneficiary safeguards and finally who is at risk. There is no a priori reason to assume that Medicaid beneficiaries cannot participate productively in a capitated program and I am enthusiastic about attempts to bring Medicaid beneficiaries into the "mainstream" of American health care.

INFANT MORTALITY

The infant mortality issue is one that clearly deserves federal action. There are abundant studies to show the cost-effectiveness of early prenatal care especially for those at high risk of low birth weight babies and babies of teenagers. The administration is showing good sense in making this proposal.

REIMBURSEMENT LIMITS ON NON EMERGENCY CARE

I certainly agree that Medicaid could save money and beneficiaries receive better care if non-emergency care was given in an office rather than an emergency room. I am concerned, however, with the practical effect of this proposal which may be to limit access to care to those least able to find suitable alternatives.

SUMMARY

In its debate over the FY88 budgets for Medicare and Medicaid, this committee will have to make many decisions under conditions of substantial uncertainty. It will have to weigh the effect of each cut on the quality of care given to the beneficiaries of our public programs as well as the long run effects on the viability of the provider community which, of course, will affect access and quality in the future. I am not certain that the committee can protect quality and access AND sustain the budget reductions proposed by the Administration. I do believe, however, that the major policy thrusts of the Administration are correct and can with modifications be translated into good public policy if not with the budget savings proposed.

Thank you for the opportunity to appear before you. I would be happy to answer any questions you may have.

Senator **Mitchell**. Dr. Weiner.

STATEMENT OF JOSHUA WIENER, PH.D., THE BROOKINGS INSTITUTE, WASHINGTON, DC

Dr. **Wiener**. Thank you, Mr. Chairman.

I want to begin with some general remarks about policy directions for Medicaid, but the bulk of my comments will be on long-term care for the elderly.

The general policy direction of the Medicaid program should be expansion of eligibility and coverage. Despite a substantial increase in the number of persons below poverty over time, the number of Medicaid beneficiaries has remained virtually constant since 1975. In this context, the Administration's Medicaid cap proposal is, in my view, indefensible. Expanding eligibility and services for children deserves the highest priority for expansion.

Turning next to long-term care, everybody is unhappy with the long-term care system. Nursing home costs, which can easily exceed $20,000 a year, are by far the leading cause of catastrophic health care costs. Public expenditures for nursing home and home care for the elderly will exceed $20 billion in 1988 and are increasing rapidly.

In his recent report on catastrophic health care costs, Secretary Bowen recommends relying solely on private sector approaches, such as private long-term care insurance and individual retirement accounts for long-term care, to solve the problem of catastrophic health care costs and rising public expenditures. While the expansion of private sector financing mechanisms is desirable, they cannot be the total solution.

Even with very generous assumptions about who would participate, the private sector approaches are very unlikely to finance more than a modest proportion of total nursing home and home care expenditures, and will have only a small impact on Medicaid expenditures and the number of people who impoverish themselves down to Medicaid financial eligibility levels.

Private sector options have a limited impact because they are too expensive to be affordable by most elderly and are flawed by limits that reduce the amount of financial protection that they offer.

The limitations of the private sector solutions means that some form of public insurance is needed, most likely through expansion of the Medicare program. Only the public sector can meet the basic needs of the vast majority of the elderly. The costs of such a program, while certainly not trivial, need not be overwhelming if we are smart enough to build up the financial reserves to pay for the baby boomers as we are doing now with Social Security.

In order to solve the problems of long-term care, we need a two-tiered public/private approach that is similiar to the relationship between Social Security and private pensions. On the first tier, we need an expanded public insurance program that will provide a modest degree of financial protection for everyone. Like Social Security, the program should provide a floor which prevents individuals from becoming impoverished. On the second tier, private sector financing mechanisms, like pensions, should fill in the gaps and provide a higher level of financial protection for those who want it. It is likely that the use of private sector financing mechanisms will substantially increase in the future and that is all to the good.

The proposals by Secretary Bowen to improve the financial protection against catastrophic health care costs by expanding Medicare coverage are a step in the right direction. However, limiting that protection to hospital and physician costs leaves the gapping hole of nursing home and home care expenditures that even a vastly expanded private sector cannot fill by itself. A combination of an expanded public insurance program and supplemental private initiatives provides the best hope of providing protection against catastrophic costs for all elderly and provides a rational way of raising the money to pay for those costs.

[The prepared written statement of Dr. Wiener follows:]

WHAT SHOULD BE DONE WITH MEDICAID AND LONG-TERM CARE?*

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* These opinions are those of the author and should not be attributed to other staff members, officers or Trustees of the Brookings Institution.

Testimony before the Subcommittee on Health, Committee on Finance, United States Senate, Washington, D.C., January 29, 1987.

Thank you, Mr. Chairman. I want to thank you for the opportunity to testify today. I will begin with some general remarks about policy directions for Medicaid, but the bulk of my comments will be on long-term care for the elderly.

The general policy direction of the Medicaid program should be expansion of eligibility and coverage. Despite a substantial increase in the number of persons below poverty over time, the number of Medicaid beneficiaries has remained virtually constant since 1975. Millions of children and working age adults are without any health insurance at all. In this context, the Administration's Medicaid Cap proposal is indefensible. The Administration's previous Medicaid Cap proposal only offered new ways new ways to reduce services and eligibility. In my own view, expanding eligibility and services for children deserves the highest priority.

Turning now to long-term care, no other part of the health care system generates as much passionate dissatisfaction as does the organization and financing of nursing home and home care services for the elderly. Nursing home costs, which can easily exceed $20,000 a year, are by far the leading cause of catastrophic health care costs. Contrary to the belief of most elderly, Medicare pays for only 2 percent of nursing home services; private insurance pays for less than 1 percent. Frequently, nursing home patients use their entire life savings to pay for their care and once totally impoverished depend on Medicaid. Public expenditures for nursing home and home care for the elderly will exceed $20 billion in 1988 and are increasing rapidly. The problems are great now and will prove to be greater in the future.

Projections of current age/sex nursing home utilization rates suggest that there may be four times as many elderly in nursing homes in 2040 as there were in 1980.

In his recent report on catastrophic health care costs, Secretary of Health and Human Services Otis Bowen recommends relying solely on private sector approaches—such as private long-term care insurance and individual retirement accounts for long-term care—to solve the problems of catastrophic health care costs and rising public expenditures. While expansion of private sector financing mechanisms is desirable, the research that we have been doing at the Brookings Institution strongly suggests that they cannot be the total solution.

Even with extremely generous assumptions on who would participate, private sector approaches are very unlikely to finance more than a modest proportion of total nursing home and home care expenditures and will have only a very small impact on Medicaid expenditures and the number of people who impoverish themselves down to Medicaid financial eligiblity levels. For example, by the year 2018, long-term care insurance may account for at most 12 percent of total nursing home expenditures and may reduce Medicaid expenditures and the number of Medicaid nursing home patients by at most 5 percent.

Private sector options have a limited impact because they are too expensive to be affordable by most elderly and are flawed by limits that reduce the amount of financial protection that they offer. Most private long-term care insurance has prior hospitalization requirements, pre-existing condition exclusions, age limitations on who may purchase policies and reimbursement levels that do not increase with inflation. The difficulty is that improved insurance coverage and affordability are tradeoffs. That is, coverage improvements are likely to make products more expensive, thus reducing the number of people who can afford them.

The limitations of private sector solutions mean some form of public insurance is needed, most likely through expansion of the Medicare program. Only the public sector can meet the basic needs of the vast majority of the elderly. The costs of such a program need not be overwhelming, especially if we build up financial reserves to pay for the baby boomers as we are doing with Social Security. An annual 2.5 percent payroll tax (employer and employee combined) would pay for a very generous expansion of Medicare nursing home and home care benefits and all Medicaid long-term care expenditures. It would require 1.6 percent of payroll to finance the current program of Medicare and Medicaid expenditures. Less generous programs could be financed with lower taxes. The payroll tax could also be reduced by charging the elderly premiums and by reintroducing more extensive estate taxes.

In order to solve problems of long-term care, we need a two tiered public/private approach that is similar to the relationship between Social Security and private pensions. On the first tier, we need an expanded public insurance program that will provide a modest degree of financial protection for everyone. Like Social Security, the program should provide a floor which prevent individuals from becoming impoverished. On the second tier, private sector financing mechanisms, like pensions, should fill in the gaps and provide a higher level of financial protection for those who want it. It is likely that use of private sector financing mechanisms will substantially increase in the future and that is all to the good.

The proposals by Secretary Bowen to improve the protection against catastrophic health care costs by expanding Medicare coverage are a step in the right direction. However, limiting that protection to hospital and physician costs leaves the gapping hole of nursing home and home care expenditures that even a vastly expanded private sector cannot fill by itself. A combination of an expanded public insurance program and supplemental private initiatives provides the best hope of providing protection against catastrophic costs for all elderly and provides a rational way of raising the money to pay for those costs.

Senator **Mitchell**. Thank you very much, Dr. Wiener.

Since we began, Senator Heinz has joined us. Welcome, Senator. Do you have an opening statement that you care to make?

Senator **Heinz**. I do, but I would like it to be put in the record.

Senator **Mitchell**. All right. Without objection.

Then in accordance with the rules of the committee, we will have a period of questioning limited to five minutes per Senator. And we will just keep going around until everyone has asked all the questions they want to. And in accordance with the rules, we will go in the order of questioning in the order that persons arrived.

Dr. Altman, you stated, and others agreed with you, that you thought Part A and B of Medicare ought to be combined. Would you expand on that somewhat? What would you do with respect to the financing? As you know, they are financed in an entirely different manner now. How would you integrate the two?

Dr. **Altman**. Well, the financing is an issue that needs to be addressed separately. I personally believe in the value of patients or the citizens, in general, paying the premium. So I would not have it totally financed by taxes. I do believe that you could put together the combination of the payroll tax financing for Part A, with a combination of premium financing of Part B.

I don't think that is a critical issue. As a matter of fact, it may turn out that when you put it all together, the financing is not out of line. I do support, however, what Karen and others have said, is that to the extent that we want to limit the amount of premium, it can be income related.

So the financing is a problem. But I am more concerned with the other side, which is the payment to the provider system and the coverage.

Senator **Mitchell**. Why don't you talk a little bit about that, sir?

Dr. **Altman**. Well that is where we are really at odds. I mean, we at the Prospective Payment Assessment Commission, have just seen over and over again the problems of people being concerned when they are discharged early. Now being discharged early, as Dr. Rubin indicated, is not necessarily a bad thing, if there is somebody at the other end of the hospital that is there to provide people with adequate and high quality home and outpatient care. Even that exists. But what many, many Americans face is that they now find themselves having to pay for services that prior to the PPS system they got for free. And so they turn on the PPS system. It is a natural outgrowth, but it is the wrong place. Because what happens is the services move from Part A to Part B. Well, the Medicare benefits doesn't know from Part A to Part B.

I defy any of us to try to understand those benefits. My mother-in-law give it to me, and I turn around and give it to an advisor. [Laughter.]

So what has happened is that we created this artificial distinction, which, as I said, made no sense really. In my testimony, I said it made sense in 1965. It really did not. But now it surely doesn't make any sense, because the delivery system does not play by our set of rules. They are really nasty. I mean, we have a Part A and a Part B but the delivery system runs across the gamut.

We saw two major aspects, for the patient and organizing a coinsurance rate that makes sense, but also from the ability to control the level of spending. Several of the witnesses said we have to move to a managed care system. Well I defy anybody to manage a care system when they are two totally different programs.

Every managed care system that we see that works does not make that distinction, whether it is an HMO or a PPO or a social HMO. They don't look at it that way.

So we have to do it or we are going to continue to bifurcate on the patient's side, and we will never be able to control this balloon.

Senator MITCHELL. Dr. Rubin said that there has been no wholesale decline in quality of care. Leaving aside the question of subjective judgment as to what is a wholesale decline, I think that he is suggesting basically that there hasn't been any major or worrisome decline, although you indicated there had been 100,000 people, and I suspect that is some cause for concern. I would like to ask the other members of the panel, and Dr. Altman may reach I think the same conclusion——

Dr. ALTMAN. Yes, sir.

Senator MITCHELL [continuing]. If they agree or disagree. If they could just briefly comment on that aspect of it. Mr. Zimmerman.

Mr. ZIMMERMAN. Unfortunately, I guess I am starting to sound like someone else. I don't agree or disagree. I think the evidence is just not available for anyone to take a silent position. My office has reported that. And I will work with Senator Heinz. And I think it is an open question. People just don't know, and more research is needed, or analyses needed, and then maybe a better understanding will be achieved. At this point, I can't go either way until that information is available.

Senator MITCHELL. Dr. Davis.

Dr. DAVIS. We have reduced the hospital stay by two days. And I think we have to be particularly concerned about the 8 million elderly people who live by themselves. A recent Harris survey sponsored by the Commonwealth Sun Commission on elderly people who live alone found that the majority of these elderly people care for themselves following hospital discharge.

We also found in that survey that 19 percent of Medicaid beneficiaries who were hospitalized, elderly beneficiaries, said that they were discharged too soon.

So I think we do have to worry about subgroups of the elderly population, those who are poor, those who live alone, and whether there is adequate convalescent care for them.

Senator MITCHELL. Dr. Meyer.

Dr. MEYER. I think if you think in terms of critical problems of quality coming up, such as would be seen in readmissions, or serious readmissions, we do not have the evidence on a broad scale that that is occurring. But I think what I sense is occurring, we just did a recent telephone survey for the AARP that gave us some at least widespread anecdotal evidence of this is that people are going home. They are not so critical that they have to be readmitted. But they are having trouble accommodating to the new things they have to do, such as IV feeding at home, which is not covered by Medicare. More and more people are having to do IV feeding at home. They go home with tubes. They go home with complicated needs that aren't covered by nursing. And it is costing them money, more money than it did before.

So, no, they are not dying from this in many cases, but they are having problems. And I think that leads to this notion that both the private coverage and the public coverage have these enormous gaps on the custodial side. They don't mesh. They replicate each other. They fill in all the co-pays and deductible. And then when you go home, you aren't covered at all. And there is not much, in many cases, voluntary network there to supplement.

So here, as elsewhere, I think you need private coverage to take over where the public leaves off, and we don't have that.

Senator MITCHELL. My time is up. I will get to the rest of you on my second round. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Professor Reinhardt, you made a very provocative statement which demands to be pursued. You indicated that our health system is, in fact, awash in money, and then you talked about the differences between Canada and the U.S. in terms of health spending as a portion of our respective GNPs.

That interests me. When any of us pursue at the state or the national level a health initiative, there is the assumption or the fear that we won't be able to pay for it.

And so it brings up a question of whether we are focusing on the right things? You are suggesting that we can do a lot more than we are by being more efficient. I guess I would like to ask you what the Canadians are doing, and why are they more efficient? And what are the things they do that we don't? And do other members of the panel agree with your assumption that by being more efficient we will have the money to be bolder, merge Part A and Part B, undertake catastrophic coverage, save rural hospitals, and pursue all kinds of other worthy goals? Or is that not agreed to by other panel members?

If you could address the Canadian situation, first, and I will ask the other panel members to address your premise.

Professor REINHARDT. First of all, Senator Rockefeller, I would like to draw your attention to the Health Care Financing Review, Fall 1986 issue where you have at Figure 4 a table that shows you what other nations spend on health care, and we are by far the highest in expenditures.

I don't know quite the answer of whether we are less efficient than the Canadians or more wasteful. That is, however, a question that I think this country finally—it is a very insular country, the United States—I think we should look abroad, because, clearly, the issue of catastrophic care for the aged is not a major issues in Canada in the sense that an adult would say we cannot afford to pay for this. The Canadians pay for that somehow.

The question is then, for instance, you might research how does someone die of cancer in Canada? What do they miss that Americans who die of cancer experience?

I think a major research effort should be undertaken to see how do these other nations do it. Do they die more frequently of illnesses? I think you will see no health statistics that would show the Canadians to be less healthy than we are, or to have higher mortality rates. Certainly not higher infant mortality rates.

My hunch is that we are spending money in the wrong way. We probably wait too long before people go to the doctor; let illness become too serious.

I think it is a challenge—that is how I would like to phrase it—upon this nation and this delivery system to show that for the extra money there are indeed commensurate benefits. If I had to bet my own fortune on it, I wouldn't bet that we are getting commensurate benefits. We are misallocating these funds.

Senator ROCKEFELLER. Well assume for a moment that we are. Do you think that this demand for catastrophic insurance is the primary problem that we face, or should we be looking at something ever broader?

Professor REINHARDT. Well, clearly, catastrophic illness has to be treated and paid for somehow. The issue is not if it gets done or not. The real issue is one who bears the burden. Should families be financially devastated because one of their loved one dies, or should that agony be socialized, as most other nations do it. That is really the issue. And to be studied here is that in Canada clearly the agony is socialized and not visited upon the individual family. And we could do this too. There is no question about it.

Of course, you cannot do this when you write, essentially give the providers a key to the public treasury and say do whatever you think is right, and then go to the U.S. Treasury and take whatever you think is usually customary and reasonable. You cannot do that. There has to be negotiated fees. And hospitals in Canada have budgets that they work with. And you could do it that way. HMOs are, in a way, Canadian systems of a sort.

Senator ROCKEFELLER. And under those HMOs—in West Virginia we have just one—do you worry, or do any of you worry, that we will develop a two-tier system of care in which those with lower income won't be able to get good enough health care or afford as much, and those with higher incomes will? Is there a concern about that?

Dr. ALTMAN. Experience we have had in the past indicates that those HMOs that have a balanced portfolio, if you will, of patients do as well for the poor as they do for the wealthy. What you have to be concerned about are poor people's HMOs, and then you really do have a potential problem. And ultimately you are going to have to depend upon the ability of patients to leave.

Government really can't regulate though. And so, therefore, you do need a balance.

Let me just indicate that I support, like everybody else, catastrophic. I would put a strong plea to be careful because the ability to waste money on that side is second to none. We have been doing on the private side analyses of how to control health care spending, and the biggest savings are on the high cost cases, and not on the low cost cases. And if you open a catastrophic payment system, you are giving the keys as well as the Mercedes to the delivery system to the Treasury.

I am not sure I have the right answer to it. I strongly support catastrophic. But I would do it in a tightly controlled, state-run managed care system or it is just going to go out of hand.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Senator MITCHELL. Senator Durenberger.

Senator DURENBERGER. Thank you.

Well why don't we pick up there and try to design a catastrophic benefit. Does everyone on the panel presume that some kind of case managed, better managed system, is necessary to prevent overutilization if we enact the catastrophic? Or does anybody or everybody buy Stuart's theory that if we go to catastrophic we open the flood gate, particularly if we go to everything over $2,000 or some fixed dollar amount, unless we have some kind of case management?

Dr. RUBIN. Senator Durenberger, I would certaily concur with what Stuart has said. My concern is that, particularly in my experiences as a nephrologist dealing with patients with end stage renal disease, common sense frequently tells you that there are certain things that ought not be done from the perspective of public policy. However, as Professor Reinhardt and others have said, and as you well know, under the ESRD benefits that have been in place since 1972, the Congress has basically said that nobody in this country should die of end stage renal disease; so, therefore, you pay and provide services far beyond what happens in other countries.

Professor Reinhardt talked about Canada. It would be an instructive research to take a look at not only what people die of, but more importantly what they are treated with. For example, how many people get bilateral hip replacements or are allowed to suffer? How many people undergo corornary artery bipass grafts, which there is now abundant evidence that suggests it doesn't prolong life at all, but certainly improves the quality of that life while you have those years.

Capital investments in new technologies in Canada is no where near what it is on a per capita basis in the United States.

My concern is yes, I think managed care is very important. I would hate to have the responsibility as a public official and certainly as an elected official to have to write the rules for that managed care, because then the issue will really get sticky.

Senator DURENBERGER. Well this is one of the important issues as we pick on the Administration and lift up Otis Bowen as the hero as we have been doing during the last 24 hours.

This is a very crucial issue. I think it is justified for the President or Supreme Court or anybody else that I have criticized to raise the issue of opening the flood gates or overutilization. It may well be that they are already open. We don't know if Medigap is servicing it right now so that it is not a great problem.

The second question concerns the issue of combining A and B and what we mean by catastrophic. I think you know where I stand. It sounds like a lot of people on this panel agree that it makes some sense to make Medicare look as much like the employment-based insurance that we are used to as possible. A combination of A and B and your catastrophic then is either a dollar amount of a percentage of income, or whatever criteria you use, over some combination of your normal qualified medical expenses.

Is there any disagreement on that? That we ought to combine A and B and have a combined catastrophic? The Administration's answer to that, or objection to that, used to be that you are going to get overutilization on the physicians' side and the medical side in particular.

Dr. **Davis**. I would support that. I think we can look to the experience of the employer-based plans. Many of those have moved over the last 10 or 15 years to covering catastrophic expenses. So that they put a maximum ceiling on the amount their employees and dependents have to pay out of pocket. And they have had a variety of utilization control, prior authorization, mechanisms for reviewing claims in advance, even of services being rendered, to put necessary controls on that.

The only point I might raise, when you talk about—I would put A and B together, the benefits together, single out of pocket expense limit across A and B. I would do it in the dollar amount rather than a percent of income. I think that that is difficult on the benefit side to administer an income related ceiling or deductible. I think if you want to get more progressivity you can do it through the financing side.

But I think what we need to bear in mind is that we have 7 percent of Medicare beneficiaries who are hospitalized more than once a year. They are paying on average $2300 a year. They have a median income of 10 or 11,000 dollars a year. That these are quite serious financial burdens on people, and we really need to guarantee a kind of protection.

Senator **Durenberger**. The last question is of the generational issue. I take the view, and I think the Administration does, that the benficiaries ought to pay for this catastrophic coverage rather than sending it to their kids in the form of a payroll tax or to the taxpayers again like we have been doing in the past. If that is true, then is there a strongly held view here in terms of how to pay for it? Premium deductible. You now have two deductibles with one premium and some co-insurance. Those are the three normal ways to go about it. And then if we are going to use what is now being called the Davis-Rowland idea income testing. It used to be mine but I let the Democrats have it. Is income testing at the premium level preferable to what we read in the paper this morning in terms of income testing at some kind of utilization level?

Dr. **Meyer**. Well I think it would be good to rely on premiums, but there are other ways too. And I think we ought to share it among the generations, frankly, because young working people are going to be elderly some day, and they ought to put something in. There should be a balance.

But I think there are a number of unmet needs even in this system that is awashed with money. One of them is catastrophic illness. One of them is SSI, and not even bringing you even up to the poverty line. And I think it is reasonable to think in terms of greater rate of taxation of Social Security benefits, for instance, by making it comparable with the way we tax private pension, or other measures like that, as asking the more well to do elderly to contribute some, not only to catastrophic illness but to SSI an adequate safety net. Only half the poor participate in SSI and so on.

And I also think it is reasonable to think in terms of taxing more employee benefits just as we ought to tax more government benefits.

You and I have talked before, and you have been a leader in proposing a cap on employer contributions to health insurance that can be excluded. That is controversial, of course. Others have looked to the pension area. I don't think that is as important as the principle that we all ought to contribute something, A, and B, that it ought to be progressive, that those who are the most well to do pay the most.

So I would broaden it from premium somewhat. But I agree with Karen, the last thing you want to do is just impose higher cost sharing and make a sick tax.

Senator MITCHELL. Thank you very much, Dr. Meyer. Senator Chafee.

Sentor CHAFEE. Thank you, Mr. Chairman.

I would like to change the focus a little bit if I might toward doing what we can to keep the elderly and the poor healthier. For example, Dr. Meyer talked about how ridiculous it is that he can't even cover a physical for preventive reasons, preventative reasons.

My first question is, is there any evidence that other nations are doing better than we are in keeping their people healthier through government programs, through better care for poor children physical examinations, and so forth?

We have heard that we are awashed with money, that Canada is doing great things in caring for their sick and their elderly. Do we have any evidence that they are keeping their people healthier? Anybody?

Dr. DAVIS. Certainly if you look to a country like Iceland that has the longest life expectancy for men and for women than any country in the world, we know that they do take prevention very seriously, so that they decide on certain services where there is good infant care, certain preventive cancer screening services, and keep track and make sure the entire population has it available. So they have made major efforts on the prevention side and that has certainly contributed, along with a lot of other factors.

Senator CHAFEE. Well, let me ask you, do you think significant changes could be made in the postponing of hospitalization or nursing care homes if we went all out on preventive medicine? Do you think we would get significant results? Anybody?

Dr. ALTMAN. I wish I could be more supportive of that because surely it is the right way to go. And I know there is a lot of work going on in the area of prevention and promotion. But I think, following Mr. Zimmerman's comments before, there is just no evidence to indicate that we could feel comfortable. I think if we did that as an alternative to what we are supposing, I think we would find that we have the problem still there. Nevertheless, I would not argue against continuing to learn. I think we have a lot more to learn in that area. But there is no evidence to support that. We could see major changes.

Senator CHAFEE. Well certainly we could prevent infant mortality or reduce infant mortality.

Dr. RUBIN. Senator Chafee, I think in the Medicaid program there is no question that there are a number of things that could be done on the preventive side, and you put your finger on one of them. Clearly, there is an abundance of evidence to suggest that prenatal care for lower income mothers as well as teenage pregnant women substantially reduces the incidents of low birth rate babies and prematurity, and, consequently, is, in essence, a very good investment on funds. And as you know, there is an infant mortality initiative in the Administration's proposal.

Clearly, blood pressure treatment and screening has been shown again to be very cost effective, particularly among those that have a predelection for hypertension.

Senator **Chafee**. Well the relationship between nonsmoking and having a stroke is direct.

Dr. **Rubin**. Absolutely. And I think as well as nonsmoking and heart disease. So I think that there are a number of things that can be done. I think that a lot of the preventive kinds of things in terms of immunization as well are more a function of poverty than of the technology that is available to promulgate those preventive changes or technologies.

Senator **Chafee**. Well I find this a little bit discouraging. Maybe that is why you are here, to discuss the Medicare and Medicaid cost side of it. But I must say it is a little discouraging. There seems to be a singular lack of interest. And I am not saying you but the nation overall in trying to keep people healthier.

Let me ask you another question. I had some hearings at home on this same subject that you are discussing here, and one of the points they raised was the lack of people's interest in the field of geriatrics—dealing with the elderly. They felt that people didn't want to work in nursing homes. It doesn't mean they didn't want to be nurses, but they didn't want to work in that atmosphere. Is that a common problem across the nation?

Dr. **Altman**. Senator Chafee, as someone who used to be on the Brown faculty, I know that Brown is one of the schools that is making major strives in introducing geriatric medicine into its medical school as well as others. And so I think on the physician's side and the high reimbursement side, I think the flow of people will increase. Where you have the problem is what you put your finger on, and that is that the nurses and the aides are so poorly paid, and the conditions are so poor, it is really hard to ask and expect large numbers of well trained individuals to go into them. And so I think we will not see substantial improvement in that until we start putting the dollars in there and getting their pay higher. But on the high side, I see a big change over the last five years.

Senator **Chafee**. Of interest to the doctors who are going to do it.

Dr. **Altman**. Yes.

Senator **Chafee**. Thank you.

Senator **Mitchell**. Thank you, Senator. Senator Baucus.

Senator **Baucus**. Thank you, Mr. Chairman.

Mr. Zimmerman, among the questions we are obviously going to face as we try to design catastrophic health insurance are whether to provide for acute or long-term care and who the beneficiaries are. Are they elderly Americans or other populations? And part of that question is the degree to which it is public or private health insurance.

I was struck by your testimony which indicated that GAO has found the loss ratio for Medigap policies is around 60 percent.

Mr. ZIMMERMAN. That is correct, sir, for the privates, and some 81 percent for the Blue Cross Blue Shield plans. We wrote that.

Senator BAUCUS. And you pointed out that it is 97 percent for Medicare. I think you said that the administrative and overhead cost for Medicare are lower than they are for——

Mr. ZIMMERMAN. That is what it comes out to.

Senator BAUCUS [continuing]. For Medigap.

Mr. ZIMMERMAN. That is correct, sir.

Senator BAUCUS. Now what does that imply? What conclusions can you draw from that?

Mr. ZIMMERMAN. The first conclusion I would draw from it is the adding an acute care Medicare provision to the existing Medicare program will probably cost little in terms of administrative cost to administer. It would be just another provision added to the existing program.

In the acute care prospective, of course, you are talking about a whole different ball game. Medicare is basically—in the long-term care prospective you are talking about a whole different ball game. Medicare is basically in an acute care program. There is some provision for nursing home care.

But I was surprised with that information myself. And it shows that we have a very large existing system in place that deals right now with close to 75 or 80 billion dollars worth of payments to the provider community. I don't see any reason why adding another dimension of benefit to it would overtax it or create difficult administrative problems. And it would probably yield a better return if it is done on a premium basis to the people who are paying the premiums.

Senator BAUCUS. That is with respect to acute care.

Mr. ZIMMERMAN. That is correct, sir.

Senator BAUCUS. Can you draw any conclusions with respect to catastrophic coverage that would include long-term care?

Mr. ZIMMERMAN. I am not quite sure I understand exactly how that will play out in the end. I mean we are talking about, you know, when you look at the size of our population, that couldn't ultimately be required to rely on catastrophic long-term care. It strikes me as a very, very big problem, the least of which would be how we are going to administer it. I think it is a question of how we are going to fund it.

Senator BAUCUS. Why are the Medigap administrative costs so high?

Mr. ZIMMERMAN. Excuse me.

Senator BAUCUS. Why are the Medigap administrative costs so high?

Mr. ZIMMERMAN. Well I think, first off, they are allowed by law to be somewhere in the neighborhood to exceed 60 percent if I am not mistaken for the privates and 75 or so for the group plans.

I think the reason why it may be high is that there is an awful lot of plans out there selling insurance to relatively small populations and, therefore, their costs are high. They have to pay advertisement. They have a certain amount of overhead and I am quite sure they are making a profit.

Senator BAUCUS. Does GAO have any tentative recommendations as to how we can improve that loss ratio?

Mr. ZIMMERMAN. Well we can mandate a higher loss ratio, Senator. We can say if you want to participate in Medigap, you are going to have a 75 percent loss ratio.

Right now it is almost an advisory thing anyway. I don't think there is a loss ratio that is in the existing law. It is a mandated thing. It is a target or an objective that the plans have to achieve.

But if you look at our report, there are very many plans out there selling Medigap insurance. Some are relatively small; some are pretty good size. Some of the big ones, in fact, have a pretty good loss ratio in terms of beneficiaries' benefits. But by and large it is a question of having an awful lot of people out there competing for the market.

Senator BAUCUS. Do you think we should re-visit Medigap insurance?

Mr. ZIMMERMAN. Sure.

Senator BAUCUS. What is your strongest recommendation? What is the top of your list of priorities?

Mr. ZIMMERMAN. Off the top of my head I think in terms of Medigap, if it is going to exist, I am not quite sure I understand exactly how or to what extent it would exist. If, for example, Medicare took over a catastrophic provision, because we would just be talking about, at the most, $2,000. And I don't know whether people would want to go out and buy another policy to cover the $2,000 that isn't going to be covered by Medicare. So it may go away,in fact, if Medicare takes over the catastrophic acute care provision.

Senator BAUCUS. Quickly, Dr. Altman, what can we do to encourage more rural health care?

Dr. ALTMAN. Well let me focus on the PPS system in hospitals. I think that the system was primarily designed with an urban hospital bias. And we have been looking at three areas to improve the rate of dollar flow into rural areas. The first is to make a structural change in the wage payment by separating rural areas into two different categories, what we would call the rural rural and the rural urban. In such a way, we think we can provide dollars more targeted to a way they have to pay.

The idea that rural areas simply because they are rural can pay lower wages just doesn't seem to bear out. Some place they have to pay as high wages in urban areas. So that is the first.

The second is the PPS system does not have a volume adjustment. And I think it is a mistake for the total system, but it is a real mistake for the rural areas.

You know better than I do, small changes in volume for a hospital really just create havoc with their balance sheet. And the PPS system just encourages more admissions. And it really hurts less admissions.

So we think that there should be changes in the volume adjustment. We have to go slowly because we want to learn from that.

The third area that we are looking at, which is much more controversial—I think Senator Mitchell mentioned in his opening statement, and we will be studying it—is whether we should, in fact, abolish the difference between urban and rural, and, in fact, have one payment system.

Now I am not here advocating it nor am I suggesting that ProPAC is advocating it, but we have decided to put it as a top agenda item for next year's research. And I think all three of them, hopefully, will provide a flow of dollars which is more commensurate with the need, and then with the dollars will come the services. The services are there, but if the dollars aren't there the providers won't stay and they won't come.

Senator BAUCUS. All right. Thank you.

Senator MITCHELL. Thank you, Senator Baucus. Senator Heinz?

Senator HEINZ. Mr. Chairman, thank you.

My first question is stimulated by something that Dr. Reinhardt said as I came in from a hearing on the homeless, which was that we can't be faulted for the amount of money we spend relative to other countries, and that made me reflect on a comment that Bob Butler made to me about a year ago. Bob, as you recollect, was the head of the National Institute on Aging from its inception until a few years ago. I asked him, given that we spend 60 or 70 billion dollars a year on those people who are 65 and over and under Medicare, that improvements in mortality or morbidity can we attribute to this investment?

Clearly, people are living longer. The quality of life has improved. But to what extent can those improvements be attributed to that annual investment?

His answer was, there is no evidence that you can attribute much of any of it to the 60 to 70 billion dollars we spend.

My question to you is, do you have any data that either support or contradict that finding? And if you can support that finding, what does that imply or mean? What should we do?

Dr. RUBIN. Senator, I can answer that question, at least in one regard, very quickly with perhaps a compelling example.

Prior to 1965, the rate of cataract surgery for those people over age 65 was very, very low. As this committee is well aware, the rate for cataract surgery in those 65 and older since 1965 has skyrocketed.

Senator HEINZ. It is, to say the least, an impressive accomplishment.

Dr. RUBIN. Yes.

What does that really mean aside from the fact that there are a lot of ophthalmologists who are doing very well? It means that there are a lot of people out there who couldn't read, who were functionally dependent that are now functionally independent. So I think that is just one example of the kind of thing where the institution of Medicare, not all of the 60 to 70 billion dollars, to be sure, has made a dramatic difference.

Another example is the whole technology of hip replacements for those that were crippled with arthritis, again going from functionally dependent to functionally independent because they can walk. There is no question that the majority of people, prior to 1965, had that operation been available could probably not have afforded it.

Senator HEINZ. Not to interrupt, but we all can think of numerous procedures that clearly shift the health status in a very favorable direction for many people. The question is, has anybody ever sat down and analyzed what we are getting for our investment and why? For example, it is entirely possible that we are not helping anyone to live longer through Medicare. Maybe increased longevity is from life style changes. But Medicare may be doing exactly what you say, helping people be far more independent. But has anybody ever taken a careful look at it? That is the question. Uwe?

Professor REINHARDT. Yes, Senator Heinz. That is exactly what I meant with my comment about Canada. I think Senator Chafee misunderstood me if he read into it the statement that Canadians are doing great things, and they do the same we do for less money. We don't know. And I think it is researchable, and I think we ought to look at what they do.

Senator HEINZ. That is the point. It strikes me that this is a researchable issue, from what I understand all of you to be saying, but that nobody has researched it. Congress has embarked on a rather interesting strategy for the last six years, which most of us on the committee have been a part. We have said we are going to save money in various ways in the Medicare program. And we will cut back. We will make it less attractive for people to implant pace makers that aren't needed, for example. We should take the savings and create programs to address other needs that will improve the quality of people's lives, such as hospices, although the hospice benefit doesn't function as well as it should. There is a Medicare hospice program now which we didn't have six years ago, and so forth.

What you kind of end up wondering is, really twofold. One, are there more opportunities out there than we see to apply savings to fill gaps? And another question which we apparently are not going to have time to get to at this point, but when I will lay out, is this: If we are really embarking on that strategy, assuming "savings" that can be applied to such needs as catastrophic coverage, unless the inflation rate in health care cost is really mitigated, we are making a very false assumption and our math at least cannot be correct. And let's hope I can return to that. I don't have the time to let you all comment on it, but you can reflect on it until it is my turn again.

Thank you, Mr. Chairman.

Senator MITCHELL. Thank you very much, Senator Heinz. I guess Senator Danforth has stepped out, so I will go back to my round of questioning.

I would like to resume the responses to my question regarding whether there has been any adverse effect on quality of care. And I think we have had so far two noes, one I can't tell, and two, I think, maybes. I am not sure. Dr. Palmer, let's hear from you.

Dr. PALMER. Yes. I have little, I think, to add to what, in particular, Karen Davis and Jack Meyer said. I think, very briefly, there is not evidence of wholesale reductions, as Dr. Rubin said originally. There are certainly the selected problems of the kind that were talked about. And I think, in particular, it is the poor where one should look to see where the real problems have developed in the last five to six years.

Senator MITCHELL. Thank you, Dr. Palmer. Miss Polich.

Ms. POLICH. I would also agree with Dr. Davis and Dr. Meyers. I don't see a real strong reduction at all in quality of care, but I am concerned about access to sub-acute care. And I think in a lot of areas of the country there is adequate access to sub-acute care through special sub-acute care or transitional units in hospitals, swing beds, home care, particularly in rural areas of the country.

And I should also mention there is tremendous variation from state to state, depending upon the state's regulatory environment.

There is not adequate access to sub-acute care services or transitional care services. And families and the elderly in those circumstances often bear the brunt of that in terms of extra care that needs to be provided after the discharge.

Senator **MITCHELL**. Professor Reinhardt.

Professor **REINHARDT**. I believe this country sometimes is excessively obsessed with reducing lengths of stay. I am reminded of a study done by the United Hospital Fund in New York that showed that length of stay varies very much with income class and location in New York City. That is, length of stay was very long for very poor people who didn't have a good home to return for the convalesce. And I think we should be very careful not to get too obsessed about the occasional hospital day that is delivered not for medical reasons but for socioeconomic reasons.

Senator **MITCHELL**. Thank you. Dr. Rubin, you have already commented, so we will go to Dr. Wiener. They are commenting on your comment.

Dr. **WIENER**. There is no question that PPS has resulted in discharges that are quicker and sicker, but that is, after all, what the system was supposed to do. The question is whether there are people who are discharged who do not receive adequate care in the home care setting. As we squeeze down on the acute care side, it seems to me it would be prudent to relax some of the Medicare rules having to do with home health care.

Unfortunately, the Administration is taking exactly the opposite tack. One of their major priorities has been to clamp down on Medicare home health expenditures, leaving some people in a peculiar situation. On the one hand, they are not sick enough to stay in the hospital, yet they require a level of care of home health benefits that the Administration says is too great. Therefore, they are ineligible for Medicare home health benefits. It seems to me that that kind of no win situation is intolerable.

Senator **MITCHELL**. Thank you, Dr. Wiener. Dr. Meyer said, and others concurred, that there should be an income standard applied to Medicare. I didn't hear, Dr. Meyer, whether you suggested it be in premiums, benefits, deductible, or what form, but perhaps that is not crucial in your mind.

I would like to ask each of the panelists to comment on that. Do you agree that in some form an income standard should be applied to Medicare? And if so, if you have a particular mechanism to suggest, would you suggest that?

Dr. **MEYER**. If I could just clarify, Mr. Chairman.

Senator **MITCHELL**. Go ahead.

Dr. **MEYER**. I don't intend that I oppose a means test for Medicare. I don't think we should say people above income X are ineligible for benefits.

Senator **MITCHELL**. You want to maintain universal coverage, but introduce some form of income standard?

Dr. **MEYER**. Everybody would be covered above 65. But I believe in some ways of scaling the contribution they make or through taxing some benefits under the Social Security system, or getting a greater contribution from the upper income people.

Senator MITCHELL. Right.

Since my time in this round is nearly up, I will defer asking your responses to that. I will resume with that though in my next round, and I will now go to Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Dr. Altman, you said that the supply of doctors is still growing The fact remains that in a lot of states, in Appalachian states, they are practicing in some places but clearly not in others.

You have to travel a long distance in parts of Appalachia to get health care or to get a baby delivered. And so some mothers don't get prenatal care and we have many sad cases of infant mortality and the like.

Its true, isn't it, that the National Health Service corps is being eliminated? There may be a volume of doctors pouring out of medical schools all over the country. They are not coming, however, to central Appalachia.

What is the state of mind of doctors these days in terms of serving and practicing in places where equipment is less modern, hospitals are in more jeopardy, and patients are more desperate?

Dr. ALTMAN. Well I am not sure I am the one to answer that. I am not a doctor, at least the kind that could be helpful. And I am surely not a rural person.

I would say with respect to National Service Corps, if I could put some gratuitous comment in, it was a good idea that we overloaded and made it into not such a good idea.

I do support the idea of a very small targeted group of individuals who are either hired by or provide services through some federal mandate into rural areas. I think we tried to blow that program up to be almost universal, and in the process created some huge, not so nice set of standards. We defined Bethesda as a rural area. And, therefore, anybody who was in the National Health Service Corps went to NIH, you know, was sort of granted. And by doing that, why I think we took away from what it was really designed to do.

So I don't think any national program—Medicare, Medicaid, PPS—it is a blunt instrument to deal with a very important series of local problems. And so I support, in general, a very small targeted National Service Corps. But I am not the best person to tell you what physicians are thinking.

Dr. RUBIN. Senator, maybe I could respond to that, since as a physician and also somebody that has contact with medical students, albeit at Georgetown, which is hardly a rural institution.

We have had some experience. Prior to my coming to government, I was at Tufts University, and we had a fairly successful program helping put students in Maine, as Senator Mitchell may be aware. And I don't believe that there is any diminution in the number of students that would like to go and practice in various parts of the country.

The real question that needs to be explored is whether that is the best way of providing medical care for the people in those communities. And another way of putting that is, does every community require a physician? And the answer to that may be no.

And then is there a way of financing or attracting these students? And I think that there have been a number of states, as you may be aware of, that have developed state-initiated programs that have made it attractive for these students to either return to their state or stay in their state after their medical education, and have been very successful in providing a full range of services for physicians.

Another way that has been fairly popular and generally gets some press attention is individual towns will sponsor medical students. The cost of medical education is very, very high, as everybody knows. And this is one way to get a quid pro quo, if you will. That has also been successful in a number of rural areas.

So I think that there are a number of innovative solutions that I think that physicians as a whole are willing to go there if the incentives are right and if it fits their particular lifestyle. And the best kind of people to do that are people that come from the area.

Dr. **Davis**. If I could just add to that. I am a member of the Congressional Commission on Physician Payment Reform, and I don't speak for the Commission, but one of the concerns we have is that the Medicare program tends to pay rural physicians much lower fees than they do urban physicians. And that as we look at ways of reforming the Medical physician payment system to move towards a uniformed fee schedule so that you would be paying the same rates for rural physicians as you now pay for urban physicians I think would be a very important change.

I would like to just say that I think it was a mistake for this Administration to abolish the National Health Service Scholarship Program, and that we are going to face a serious problem as this pipeline of former scholarship recipients stop coming forth.

I haven't been to a clinic in West Virginia, but I visited a number in Kentucky, the community health centers, migrant health centers, centers passed by these kinds of personnel, and they have been very effective in trying to get improved health services in many of these smaller, rural, isolated areas.

When you look at the overall supply of physicians, it is not increasing per capita in the most isolated, rural areas than in the poorest rural areas. So we continue, I think, to have a maldistribution problem that needs to be addressed by targeted programs.

Senator **Rockefeller**. I guess my time is about up, Mr. Chairman.

Senator **Mitchell**. Thank you.

Senator Chafee.

Senator **Chafee**. Thank you, Mr. Chairman.

Dr. Davis, and Dr. Meyer also, what would you say to allowing families say between 100 percent and 200 percent of poverty to try a narrowly defined insurance benefit, including preventative services for children? How do you think we could design such a benefit so it wouldn't break the bank? In other words, we probably would have to be conservative.

Dr. **Davis**. I think that is a very important suggestion, Senator Chafee. You mentioned before what we could do in the prevention area, and I think the one thing that is clear that we could have an impact on infant mortality if we had better coverage.

What we have seen in the last few years is we have had a rapid increase in the number of children in poverty, and that Medicaid, for example, has not been expanded to cover that population group.

So we have had a wider and wider gap between the number of poor children in need and those who are covered under Medicaid.

With the new legislation, states are permitted to cover pregnant women and children up to the federal poverty level. But I think that is not going to be sufficient and that we are going to need to institute a minimum income floor of maybe starting at 60 percent of the poverty level but moving up to 100 percent of the poverty level so that we get all pregnant women and children below that level covered.

Now you have raised the next point, what about those that are just above that level, at the 100 to 200 percent of poverty? I think the idea of making Medicaid available with a sliding scale premium or contribution for the near poor would also be a very important coverage.

What I would do to minimize the cost of it is to ask employers to provide a comprehensive maternity and infant care benefit for their employees and for dependents. So of the uninsured, we know that the majority of those are working at least part of the year. So if you could get as much coverage as possible by having employer plans cover that, and then anyone who is not covered under an employer plan have them contribute a premium and get covered under the Medicaid program for those in that near poor income range that you stipulate.

Senator **CHAFEE**. Dr. Meyer.

Dr. **MEYER**. Yes. I favor that. And as Karen indicated, I would extend it downward. There are a number of people between 30 percent and 100 percent of poverty who have nothing also. And they should be fully subsidized.

And I like the idea of allowing near poor and moderate income people to buy in on a graduated basis. As I said, it is an all or nothing thing.

The problem is whether you start at the front end or the back end. And we have needs both in preventive care, as you have highlighted, but we also have unmet needs in areas of long-term care that are not covered by medically needy programs or spend down programs. And, frankly, I would apply the same principle there.

You know, we were talking before about Medigap policies and loss ratios. The real fact is that whether it is Medigap, retiree benefits or Medicare, no one covers some things, like custodial care. And you cannot get any coverage for them even when you qualify for Medicaid. And in order to get even nursing home care, you have to be pauperized.

So I would also apply this not only to poor children and infant mortality reduction efforts at the front end, which is very important, but also in heroic measures, where people, a middle income family that is beginning to accumulate huge bills for nurses around the clock at home, say a stroke victim at time, nothing is covered by Medicare, could buy in to a limited benefit on a graduated basis.

Senator **CHAFEE**. Let me say before my time is up that I do have legislation in dealing with what Dr. Davis said, namely, to mandating that for an employer's insurance, a medical insurance policy to be deductible it must cover certain preventative services for the children of the employee. Obviously, that was suggested by the employers and their insurance companies. And I hope we can press on with it this year.

But do we run into a problem, do you think, that—well I would be running into a problem where the employers would say, well, this is too expensive. I will drop the whole thing. Where are we then? What do you say to that, Dr. Altman?

Dr. **Altman**. Well I worked extensively on trying to design such a mandated employer plan, and I do think you have raised a very real issue.

Back in the mid-1970s we created a comprehensive health insurance plan which we hoped would become national health insurance. And recently I testified before Senator Kennedy's committee on this. My suggestion would be that we do it in two ways. We become very conscious of that for small employers or marginal employers this can be a burden. And so what I would suggest is that we use a percentage of payroll as a base, and say, look, let's phase this in over a three- to five-year period, and maybe even provide some subsidy beyond that.

I think it is unrealistic to expect an employer to pay more than 10 percent of payroll for health insurance. And so I would phase it in, starting out at about five, seven, and so on, up to 10 percent, as a way of doing it. Because if you don't do it, you could really hurt these people.

Senator **Chafee**. The employer would drop the policy.

Dr. **Altman**. No. They could drop the employee, or they can move them on part-time basis. We are a very innovative country in figuring out ways to beating these kinds of federal mandates. And these people are very vulnerable. And I am sure if you asked them would they rather have their job or their health insurance, and what I think we are both trying to do is have them have both, and, therefore, I do think we have to be very cautious. On the other hand, I don't think it should stop us from doing it. I really support what you are doing.

Senator **Chafee**. Thank you.

Senator **Mitchell**. Thank you. Senator Heinz.

Senator **Heinz**. Mr. Chairman, thank you.

Let me return to the question that I was about to pose earlier which is, are we slowing the rate of health care cost inflation? Dr. Reinhardt has statistics that imply we are not. Are we or aren't we?

Dr. **Davis**. I would like to comment on the Medicare-Medicaid programs and address that, but also underscore the success, I think, of both Medicare and Medicaid in improving the health of the people that they serve, improving their access to care, and protecting these people from the financial hardships that medical care bills can bring.

With regard to health, as you mentioned earlier, are there indications that they have had any effect, I think there is evidence to that effect. If we look at life expectancy at age—

Senator **Heinz**. We are on a new qvestion. Have our efforts to squeeze savings out of the health care system through PPS, and other limits, been successful? Dr. Reinhardt's testimony suggests that spending keeps going up pretty quickly. I would like to understand the dynamics of that.

Dr. DAVIS. I think we can see some savings on the hospital side with PPS. Certainly the costs per admission are going up but slower than they have in the past. Look at that part of it. The Medicaid program has probably saved too much money and that has come about by cutting benefits and services.

But if you look at real growth in expenditures, across the board, those are still going up. And I think we are going to face a serious problem in the long term if we don't get a better handle in overall costs.

Senator HEINZ. Let me phrase my question a different way and maybe we can dispose of it promptly.

If there is a certain outcome that the medical profession can achieve for a patient for any given condition, are we achieving that outcome any more efficiently today—at less cost per outcome—today than five years ago, six years ago? This is total cost. This includes cost shifting to the beneficiary and all the rest.

Dr. ALTMAN. At the expense of starting a long colloquy with Professor Reinhardt, I think his statement that when you look at the total it hasn't changed, does somewhat of a disservice to some things we have learned, although, overall, I agree with him. And that is that we really have made some improvements in terms of understanding how to manage the inpatient side. So that we have seen savings both under PPS, and even more so under private. I think the big savings are under the private side.

But, on the other hand, we have also learned about the balloon theory. I mean, it just plays out, unfortunately, the way we say. And that is, we have seen it shifted to the outpatient side.

In the process though, I think we have really expanded coverage. And maybe my colleagues would agree with me that the expansion of home health benefits to the aged have really expanded services; I think needed services by and large. And Congress did that by expanding Medicare to home health. And we have seen that improvement.

Senator HEINZ. We haven't done that in the last three or four years, have we?

Dr. ALTMAN. No. But we saw a jump in home health benefits that went from about 22 percent rate of growth before PPS to about a 31, 32 percent right after PPS. And I think that is a good thing. But as I said in my testimony, we should not be so cynical to think that we never do anything on the positive side. We need to expand it. And I would suggest that what we learned on the inpatient side we have to do on the outpatient side. And as I said in my testimony, you need to do two things. You need to change the reimbursement system and have managed care.

Senator HEINZ. Uwe Reinhardt?

Professor REINHARDT. Maybe I should comment on this once more. My reaction to the, or the thrust of my testimony was to react to the notion that there have actually been cuts. The notion about is that there is less money than there was before.

The way one might look at it, you could look at phases 1975 to 1980, and then 1980 to 1983, and then 1983 and on. If we look at 1975 to 1980, Figure 2 of my statement has that in constant dollars. Costs actually in constant dollars did not rise nearly as much as the rhetoric of the day suggested. Costs then began to climb very quickly between 1980 and 1983 at a rate unprecedented in constant dollars. And then after 1983, the measures of PPS and such competitive measures as we have did take a bite and we are back on the trajectory of the late 1970s.

So I am not arguing these things didn't work. What I am arguing is there is no starvation out there. If you listen, if you read the headlines, "Medicare cut by $65 billion," you believe the program has been abolished. This is only $70 billion. That is total nonsense. That is really my point. These measures did have some beneficial effect.

Senator HEINZ. Thank you.

Let me ask one quick question of Dr. Wiener regarding long-term care. He is very involved in the Brookings study group on long-term care insurance.

You have been looking at that for, I guess, nearly two years, isn't that right?

Dr. WIENER. That's right.

Senator HEINZ. Is there any possibility that long-term care insurance will ever be successfully marketed just by the private sector alone?

Dr. WIENER. Well I think there is a very strong potential for private long-term care insurance. Looking exclusively at affordability issues, we project that, with some fairly liberal purchase assumptions, by the year 2018 maybe 40 percent of the elderly population could afford private long-term care insurance.

But that still means that most people can't. And for a variety of reasons having to do with the limitations of what the policies cover, it doesn't provide a very high percentage of total nursing home expenditures, nor does it have much impact on people who spend down to Medicaid or on Medicaid expenditures. The public programs are going to be with us and we need to return to thinking about how to make them better.

Senator HEINZ. Thank you.

Senator MITCHELL. Thank you, Senator Heinz.

I would like now to ask each of the panelists to comment on the statement made by Dr. Meyer that there should be an income standard applied to Medicare, and if you choose to do so to suggest specific ways in which to do so. Mr. Zimmerman?

Mr. ZIMMERMAN. Senator, if the purpose of that is to raise revenues for the programs, or program, then I would suggest that before we do that that we take a good hard look to make sure that the controls that are supposed to be in the programs are working correctly, you have appropriate utilization review, the fees and so on are set correctly and accurately. And if we have done all we can do there, and we need more revenues, then I think it would be an appropriate course of action.

But I am not satisfied that we have done all we can do in the area of controlling program cost. So at this point in time I would like to see more of that done before I would opt for any kind of a tax or a revenue basis, income basis I should say to the program.

Senator MITCHELL. Dr. Altman?

Dr. ALTMAN. Well while I do not disagree with Mr. Zimmerman that we can do more to redirect the flow, I think it is unfair to the elderly, particularly the poor and the lower middle class. I am more concerned in this case about the lower middle class elderly; that we are just denying them services while we are not doing very good on controlling. So I would support an income related premium. I share Karen's concern about the administrateability of putting it on the co-insurance, although my economic instincts go that way.

I would put it on the premium, but I would make sure that the money is directed right back into the program. I think you would have a lot of howls if people in the high side of the age group thought that they were just helping to reduce the deficit. So I would support it, but I wouldn't let up on trying to control spending. But I surely wouldn't wait until we do it all, or we will be here a long time.

Senator MITCHELL. Dr. Davis.

Dr. DAVIS. I would oppose means testing Medicare by conditioning eligibility or benefits on income. But I do favor, as we have mentioned, merging A and B, combining the funds that now go into A and B, the payroll tax, the general revenues, into a single trust fund that add to that trust fund a new premium that replaces the current premium. The current premium just applies to Part B and it is voluntary.

What I am talking about is a mandatory income-related premium along Senator Durenberger's plan, line, that would replace a flat premium with a premium that varies with income, say two and a half percent of income instead of a flat premium that now averages about 2 percent of income. Have a minimum premium contribution, say of a hundred dollars, a maximum premium contribution applied to, say half the actuarial value. But to adjust that premium. That it is mandatory; that it is administered through the income tax system so that you don't get the Medicare program involved in these calculations.

Senator MITCHELL. Dr. Palmer.

Dr. PALMER. Yes. I certainly think it is important to move in that direction too. And the thrust of my testimony was to say that, in part, we have got a growing gap between projected revenues and projected expenditures even under current services, and under fairly optimistic assumptions about what is going to happen to health care costs in the future. We are more optimistic than the last few years have borne out.

And I think that means that not only to finance some of the expansions that are being talked about, but simply to continue to finance the existing level. There is going to have to be the sacrifices that we talked about: increase pressure on reimbursement; increase taxes on taxpayers; and increase cost sharing of some sort on beneficiaries. And it is going to take all three. And we have to push on all three fronts. And in the latter category you do not want to do it across the board because the burden on the elderly modest means is already quite high.

So you have to do it in some way that is related to income. You don't want to do it on utilization. I think it raises an administrative headache and nightmare.

So that does leave me to come out sort of where Karen and Jack were suggesting, use the tax system to the extent possible because you have got an existing administrative mechanism; find ways of reaching the better off elderly and doing it through mechanisms that won't be administratively burdened, and pile those revenues back into the program because they are going to be sorely needed.

Senator **Mitchell**. Miss Polich.

Ms. **Polich**. I also agree with the need for some type of income standard. I don't believe that it is as much of an interest in increasing revenue but rather more of an equity issue; that we really burden the poor elderly with out of pocket payments for Medicare. And I think those need to be relieved.

I think you can do it in a variety of ways. Certainly premiums adjusted by incone; limiting total payments annually varying by income. I don't think it should be done on the basis of co-insurance, where the ill bear the cost of that.

However, there are some question, I think, or issues about what would happen in a managed care system or under HMOs, how you would income adjust on that. Through a voucher system you might be able to vary the amount of the voucher based on income. I am not exactly sure how you would do it for Medicare enrollees in HMOs. Whether you would pay the HMO a differential amount, and have the HMO collect from the beneficiary the difference in the capitation. That is an issue that I think, in my mind, would be unresolved.

Senator **Mitchell**. I will get to the rest of you on my next round. I will now defer to Senator Rockefeller.

Senator **Rockefeller**. Mr. Chairman, why don't you continue because you only have a few more.

Senator **Mitchell**. All right. But it took five minutes to get through four. [Laughter.]

Go ahead then, Professor Reinhardt.

Professor **Reinhardt**. As an economist, I do favor cost sharing at points of service, but as a human being, I am impressed with the administrative hassle and the indignities that are often applied. So I also come out on the side of doing most of the means testing through the back door, that is, income related premiums for the aged, using the tax system to achieve that.

And in my testimony, I allude to a proposal I have for the uninsured which is basically similar. It should be, I think a federal-state sales tax system to which every American is automatically entitled. Therefore, the problem of uncomplicated care would disappear, and you would finance it by an income related premium and supplement it by a tax on cigarettes and gasoline, and so on. But set the premiums such that the bulk of Americans would prefer private health insurance provided through the employer. So that way we could not only take care of the aged but also the poor baby boomer, the younger people.

Senator **Mitchell**. Dr. Rubin.

Dr. **Rubin**. In my testimony, I supported an income related premium, and I certainly would concur with that. I would disagree, although I would hope that I am as humane as Professor Reinhardt. I think cost sharing does work certainly in the private sector. I think that it is workable administratively, and I think that we should keep it. I think that the deductible also needs to be indexed in Part B so that we can keep it at the same relative rate, and perhaps we could make some allowances for the poor elderly.

Senator MITCHELL. Dr. Wiener.

Dr. WIENER. I would support income-related testing on the revenue side but not on the benefit side. Let me just suggest two ideas for raising revenue.

We have talked a lot about getting more out of the well off elderly, but we can also get more out of the well off working age population. And one of the easiest ways to do that is to remove the income ceiling that we have for the Social Security taxes. There is no reason that people who make substantial amounts of money during their working years shouldn't pay more for the Medicare program.

The other way to raise revenue, which hasn't been mentioned, is to reverse the decision of Congress a couple of years ago and start to reinstate some meaningful estate taxes. It seems to me that the federal government has a reasonable role in protecting people from incurring catastrophic costs, but it doesn't seem to me that there should be any government-insured right to pass on very large sums of money to heirs without paying some kind of significant tax.

Senator MITCHELL. Thank you, Dr. Wiener.

Senator Rockefeller.

Senator ROCKEFELLER. Just one question, Mr. Chairman. Back to rural America. In West Virginia, between 1984 and 1985, rural hospitals went from the position of making reasonable amounts of money to losing a great deal of revenue; patient days went down in my state in those two years by 19 percent, which is more than twice the national average. And there were a lot of complaints from those hospitals in the rural parts of Appalachia about greatly increased indigent care responsibilities, and about discriminatory DRG reimbursement levels, in terms of the urban versus rural rates referred to by Dr. Altman.

I would ask any of you whether you agree that this is a real problem. There is a lot of comfort in having a hospital in one's own county. That, of course, doesn't necessarily conform to the constraints of the real world. For whatever reasons rural hospitals are in real trouble. And I worry whether or not there is going to be a stream of hospital closings in places such as West Virginia.

We have some that are literally on the brink and some that have closed. Is that just a problem in central Appalachia? Is there a danger in terms of access to health care should more close? Is cost containment hurting them? What do you see in the future?

Dr. ALTMAN. Well there is no question that as you move from a cost based reimbursement system which essentially bailed out hospitals that faced declining enrollment because they just paid more for those who remained, to a system which gives a flat payment per admission, that those who were seeing reductions in admissions are facing significant cut backs in revenue.

And that is why we are trying to figure out an appropriate way of balancing that with some admission or quantity adjustment.

Now the other issue you raised, Senator, is a troubling one, and that is to what extent should the federal government bail out an overabundance of hospital beds in rural America? That is a troubling bit. And I think some compromise is in order. I think we have been blind to some real needs in rural America, and we have hidden behind the fact that we need to close hospitals there, and, therefore, we have done nothing.

I would like to see a two-pronged situation. One, recognize that some hospitals in rural America, as in urban America, should close, but for those that remain, they should be financially healthy. And, therefore, we do need to change the reimbursement system.

Dr. **Meyer**. I would like to add that we have to start by asking why we have fiscal stress in these hospitals and get to the heart of the problem. The heart of the problem is that a lot of people are disenfranchised and bring no dollars to the hospital. A lot of other people are paid by, the hospital is paid by Medicaid at some patheticly low fraction of their real cost, and then there are others who are employed but they don't have catastrophic protection. All these people end up as charity patients. They may not come in, but they end up.

I would prefer to get to the heart of those problems through the discussions we have been having today about welfare reform, about catastrophic illness protection, and then know that many hospitals will be helped by that, rather than going into the symptom, which is the stretched out hospital and trying to save it.

The problem is there are many communities you are concerned about where there is only one hospital. I understand that. We may have to save those temporarily. But there is also Philadelphia with eight teaching hospitals, and everyone of those thinks they ought to be saved. And that leads to Stuart's point. So I think that if you enfranchise people with adequate purchasing power, and then let them choose the hospital, and then if some close, so be it. And then there will be exceptions to that where we have to make emergency measures to make sure there is a provider in every community. But there is a real danger of the prop up approach, I think.

Senator **Rockefeller**. So that better purchasing power could even it out. Not save all hospitals but even it out.

Dr. **Meyer**. I think so. Not totally. But one of the reasons that hospitals aren't on a level playing field, not the only one. There's also bad management versus good management. But one of them is that some see many more indigent patients and they don't get any money for it. And to allow that to go on, and then try to bail them out in some way I think is not the prudent course.

I would get right at the heart of the problem with some way of sharing those costs socially.

Dr. **Davis**. I would second Dr. Meyer about the need for universal insurance coverage, and a lot of the problem in rural areas is that people are too proud to go if they can't afford it. So they are poor, they are unemployed, and that is not why we are seeing the hospitals used effectively.

But, again, I think we can learn something from other countries. If we look at Sweden, which has many rural, isolated areas, what they have done there is a strategy of having a primary care clinic and a nursing home facility that is all one facility. So you go to the same place. Young mothers take their babies to the same place that older people are living to get long-term care. And I think we could be a little more innovative about thinking about alternative uses of some of this hospital capacity. Something called swing bed, trying to convert it toward long-term care need, where we find in many of these rural areas that there are many older people who again need some type of support that is not available in the home.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Senator MITCHELL. Thank you. Senator Durenberger.

Senator DURENBERGER. But just on that point, you don't have to go to Sweden. You can come to rural Minnesota, maybe rural West Virginia, where they are already trying, those who can afford to change the definition of a hospital to a health care facility, and put in mental health services, and a variety of things are doing it. The problem is those who cannot afford to do it. It is those who have got the one, two, three, the little community hospitals that have got the heavy debt because they built in the late 1970s, or something like that. They can't afford the conversion to something else. They can't afford to go into nursing beds or convert one wing into apartment houses or something like that.

It seems to me that one of the areas that we haven't adequately addressed is just the federal role in the conversion or facilitating some of the capital cost of conversion. I don't think that it would be all that much. We are giving a lot of revenue foregone, and tax exempt bond financing, and a whole lot of other things. But if somehow or other in a definitional sense we would try to incorporate some of those facility conversions, I think that is it.

I don't mean to put down Sweden, but there are examples out there now already. Some of it is all defensive; people going into lines of business just to keep things going.

On the issue of the employer role, John Heinz, Dave Durenberger, a couple of other characters, last year got themselves in a little hot water because we revisted with the first father of the National Health Insurance in a whole effort to try to bring access to the health care to all Americans. And John and I, in particularly, learned in the 1982 experience with health care for the unemployed that just creating a new welfare program really wasn't the best way to go at it. But using the employer base to provide that is where we ought to be.

Well we put in a bill that came right on top of COBRA, and some of the things we were trying to do for families in COBRA—and I don't know what happened in Pennsylvania—but, boy, I'll tell you, in Minnesota, all of the small businesses, in particular, went through the ceiling and then so forth.

Now have one or more of you given little thought to the employer's—maybe this has been covered. How do we bring the employment-based health insurance into this system? Understanding and in particular I guess the problem is the small group, the 20 and unders, or whatever they are. Because there you are adding the cost of employing people. On top of the Social Security tax and all these other taxes, you are adding what I presume is a higher premium for a little group than at U.S. Steel or the auto workers or something else.

But one of our thoughts was to go to this state pool for the medically uninsurable. But at least tell the insurers out there, or whoever it is, you don't have to worry about a high medical risk because we will put them someplace else. But they still—the employers I mean—really have difficulty today dealing with their role.

And, Uwe, have you given some thought to this?

Professor REINHARDT. Well, one of the hazards of my profession is that you write down things you're thinking. I went on a limb on this one, where I wrote a little paper: "Should employers be forced to give health insurance?" And I came out no, in contrast to my colleagues on the right, special right, that is.

I think it is a taxing on entrepreneurship and employment that brings with it a whole host of other issues, such, for example, premiums, what pool do people belong to, may that set up yet other barriers to employment that we haven't thought about by certain categories of people?

Ultimately, you must ask yourself, how many intrinsically governmental chores can one really load through pseudo taxes onto the backs of entrepreneurs and business? Because I call that a pseudo tax. A pseudo tax is one where the government tells person A to pay something to person B. And it doesn't go through the government budget, so that is nice. You look like a tax cutter when, in fact, you are really raising taxes. But there is a real problem in a democracy of doing that.

Dr. ALTMAN. Can I take exception with my friend over there? We have made a decision in this country to have an employment pay system. Everything you said is absolutely right. But it is the American way and I don't see us doing away with that. And, therefore, we should build on it.

I think if we continue to say, well, that's not the employer's problem, recognizing that both of us want to do something, then it has to be a government program. I happen to agree with where you are coming from. You, I think, were out of the room.

I would do it in a three-part way. This business about the law—I think, a payout ratio is probably a better term—for Medigap, I think there are ways of increasing the payout ratio. And the way you suggested, I would have a state mandated pool, and I would have a limited number of providers in each area compete for that state pool, and mandate that there be a reasonable but not excessive amount of overhead or administrative cost in the neighborhood of 15 to 20 percent. In addition, you can have catastrophic coverage paid for by something else.

And the third part would be to phase in the mandated benefit as a percentage of payroll, say from 5 percent growing to 10 percent. Be very careful though, Senator, I would think, about mandating too much specific. Every provider group will want to be in on that, and pretty soon you will overwhelm it.

So I think you have to be very concerned about the employment.

Senator DURENBERGER. Well, we haven't mandated any benefit in what we have been criticized for. We have just set an exchange for the tax plan as a subsidy. We want continuity in there and the right for somebody to buy in. And now we are talking about maybe catastrophic.

Senator MITCHELL. Thank you, Dave.

Several of the panelists have expressed the view that Medicare Parts A and B should be merged. I would like to ask those who have not previously expressed a view on that subject to tell us whether you agree or disagree with that. I cannot recall who has previovsly commented. I believe about three or four have. Why don't we start with you, Mr. Zimmerman, and if you have expressed an opinion, just pass.

Mr. Zimmerman. I haven't, Senator. And, frankly speaking, I am surprised that we ~~are spending a lot~~ of time talking about that subject today. It has not impressed me in the past as being a major problem or obstacle to the administration of these programs, and so I am a little bit surprised by the interest, on the panelists, in particular, about merging the two together.

I, frankly speaking, don't have an opinion on it. I think they are both working. I don't think things go away when you join them up or get any better. It might even get a little bigger and a little bit more confusing. But other than that, I don't have an opinion on it.

Senator Mitchell. All right.

Dr. Altman, you have already spoken.

Dr. Altman. I have expressed on that, yes.

Senator Mitchell. Dr. Davis, you are in favor of it. Dr. Meyer?

Dr. Meyer. I favor it.

Senator Mitchell. You favor it.

Dr. Palmer.

Dr. Meyer. Yes.

Senator Mitchell. You favor it.

Dr. Palmer.

Dr. Palmer. Yes.

Senator Mitchell. You favor it.

Miss Polich.

Ms. Polich. I favor, and it is absolutely necessary if we are going to move to our managed care system.

Senator Mitchell. All right. Mr. Reinhardt?

Professor Reinhardt. I am in favor of it.

Senator Mitchell. Dr. Rubin.

Dr. Rubin. I think it would facilitate a managed care system. I think that it is not as straightforward as a number of the panelists have seemed to indicate. As Senator Durenberger is aware, we played with that idea about five years ago. And I am sure that there are other people that are smarter at administration than we were, but it is frought with danger in particularly budgetary exposure. But in principle, I think it is a good idea.

Senator Mitchell. Dr. Wiener.

Dr. Wiener. In principle, I am in favor of it. But I have rather modest expectations of what you get from it. It seems to me that you would still want to keep, even in a unified system, some sort of co-insurance on physician and other kinds of outpatient services to control utilization. Do you still have the same kinds of problems, or many of the same kinds of problems that you have under the current system.

Senator Mitchell. Earlier, Dr. Rubin opposed the Administration's proposal to apply the DRG system to some physicians now in limited form. I would like to ask each of the panelists to express his view on that. Do you support the Administration's proposal? Do you agree with Dr. Rubin? Mr. Zimmerman.

Mr. Zimmerman. Senator, I think the proposal has promise. The concept has promise. I am not exactly familiar with exactly what the Administration is proposing, but we are looking at that issue, and at this point in time I think there are some advantages, though I can't discuss them right now, to such a move.

Senator MITCHELL. Dr. Altman.

Dr. ALTMAN. With the caveat that Bob indicated about losing somewhat the physician advocate, which I think is important, I do support it, particularly for the hospital base. I think as you move away from that, our ability to construct the DRG system then makes sense, and administer it falls away. But if you focus it on hospital base services, I would support it.

Senator MITCHELL. Dr. Davis.

Dr. DAVIS. Again, I think we don't know the specifics of the Administration's proposal; but we have to understand that patients have very little choice with regard to their radiologist, anesthesiologist, pathologist, and that there is not an area where the market works at all. And so the notion of reforming that payment perhaps in a single lump sum, a diagnosed-base rate paid to the hospital, I think, looks very promising.

Senator MITCHELL. Dr. Meyer.

Dr. MEYER. Well it would be hard to do worse than the current CPR system. [Laughter.]

But I think that they may have bypassed an interim step of greater reliance on fee schedules, which we do have a little more experience with doing. And my concern about this is it may work in theory, but as one of the panelist mentioned—I think it was Bob; I'm not sure—we really don't know how to do it. And my understanding of this proposal is that it is a compromise, that the initial proposal out of OMB was to do it for all physicians.

Senator MITCHELL. Right.

Dr. MEYER. And so we ought to think about that because we don't know how to do that. And I am concerned about it.

Senator MITCHELL. Dr. Palmer.

Dr. PALMER. I would agree in principle again with the idea of doing it as Dr. Altman emphasized for the hospital-based physicians. But exactly whether the Administration's proposal is the right way to do it, we would have to see the details on it.

Senator MITCHELL. Right.

Miss Polich.

Ms. POLICH. I agree with Dr. Davis.

Senator MITCHELL. You agree with Dr. Davis, who favors it?

Ms. POLICH. Yes, sir.

Senator MITCHELL. You support the Administration's position.

Professor Reinhardt.

Professor REINHARDT. In testimony before Senator Heinz's committee, I once did go on record of saying if you must play with DRGs for position, it is one area where at least technically it can be made to work. But I am a member of the Physicians' Payment Review Committee and keep my mind open to listen to what people have to say. And one alternative might be that if it is administratively workable is to have a negotiated fee schedule that is mandatory, with mandatory assignments. So at least the myth that patients shop around for these people is one that I would like to dispute somewhere else.

Senator MITCHELL. Dr. Wiener.

Dr. RUBIN. Can I ask——

Senator **Mitchell**. We will give you the last word. That is the best word, Dr. Rubin.

Dr. **Wiener**. I would support it in principle, but I am not sure we have the technology to do it. I think we have to be very careful about overloading the DRG system. DRGs work only modestly well for hospitals as a whole. We should be careful not to use DRGs where it is not empirically justified.

So I think we need to be very careful and only do with DRGs what can be empirically justified.

Dr. **Rubin**. We heard expressed from my co-panelists this morning that the view that hospital-based physicians it was easier to do DRGs. And Professor Reinhardt said technically, and others made other comments. Dr. Davis said that patients are not consumers.

My concern, and what I said in my prepared testimony which I am going to amplify in that comment, is that I really wonder whether a radiologist would, as he currently does, recommend an additional examination to clarify a particularly difficult diagnostic issue, whether a pathologist will make an extra specimen, would do an extra stain or do an extra test to clarify the diagnosis. I would hope that if they are being paid on a DRG or fixed price basis that my colleagues in the medical profession would. I must confess to being less than uniformly optimistic about that approach. And so, therefore, I think that a lot of the same problems that are inherent with DRGs for physicians, in general, are particularly inherent with these class of physicians. And my concern is that it is so difficult to ferret out underservice in this area, that we may be doing more harm than good.

Senator **Mitchell**. Thank you, Dr. Rubin.

Senator Rockefeller.

Senator **Rockefeller**. I have no more questions, Mr. Chairman.

Senator **Mitchell**. Senator Durenberger.

Senator **Durenberger**. Just one question. Again, I hope that I am not repeating something. But has anybody raised the issue of the severity index, how important that is to PPS, just whether there is one readily available that we ought to be thinking of. Karen talked about the frail elderly and those things. Bob?

Dr. **Rubin**. I am unaware of any severity index that is easily understandable, cheap to administer, and has any kind of relationship to cost.

Senator **Durenberger**. A second question. Excuse me.

Dr. **Altman**. I would support Bob.

Senator **Durenberger**. A second question back on the rural issue again, and somebody mentioned this in the beginning. We have got two major kinds of rural issues other than the ones that Senator Rockefeller has already talked about. One is the urban-rural differential on hospitals which enriches some urban hospitals. But the other one, the more serious one, at least in my state, because we cover the state now with PHPOs as the private health option is now being called is the AAPCC. Our experience in Minnesota—and I don't know whether it will be this way in the rest of the country—is that the county by county AAPCC is a disaster, principally because it discriminates. It discriminates against conservative practitioners who out in the country have been practicing conservative, relatively inexpensive medicine. Now they have got to compete with themselves for some of this business.

But worse, because you have got situations where, by reason of a physician practice, or whatever, right next door the AAPCC rate may be much higher. You have got wide variations in reimbursement. This will skew services away from certain physicians and certain hospitals. So being simplistic, I said, why don't we have an urban-rural rate for AAPCC and see if we can think of something better? We should take the State of Minnesota, as an example, figure out how much of the 95 percent of AAPCC is for the state for the year, then take the urban-rural and split it in half and get a realistic rate for everybody in the rural area and a different one for people in the urban area. I don't think that has the same problems than the hospital DRG urban-rural has. Does anybody have a reaction to that?

Dr. **Altman**. Well there is something we might think of, and I honestly haven't had much time thinking about it. But we are learning under the DRG system to make adjustment in the national rates to reflect appropriately differences in cost of providing care. I suggested that we are thinking about breaking rural areas into two parts, the rural-rural and the urban-rural.

But one way would modify what you say but not be different would be to take a state-wide or even a U.S.-wide AAPCC and then adjust it for three aspects of costs that we know are different, such as wage rates and so on, rather than using, as you said, the county. I think the county system is as antiquated as allowing fees to vary.

Senator **Durenberger**. Well this is so transitional and so temporary. I mean, even the 95 percent thing is just something we reached for in order to start moving into the transition.

Mr. **Zimmerman**. Senator, we are looking at the whole rate setting mechanism. The data base is so old. I don't know whether it is 1977 or 1981 or something or whether, that is used for the rate setting mechanism. But we are looking at it now. We have a lot of concerns about it. And, hopefully, in the next few months we will be able to come up with some ideas as to how it can be better dealt with.

Senator **Durenberger**. Thank you, Mr. Chairman.

Senator **Mitchell**. Thank you.

Dr. Wiener, in your opening remarks you spoke briefly with some strong words about Medicaid. You specifically proposed expanding eligibility and coverage of Medicaid. Am I correct in recalling those words right?

Dr. **Wiener**. Right.

Senator **Mitchell**. I wovld like to ask the other members of the panel whether or not they agree with Dr. Wiener in that respect. Now we will give you the last word, as we did Dr. Rubin. Mr. Zimmerman?

Professor **Zimmerman**. I am sorry, sir. I didn't hear what you said.

Senator **Mitchell**. In his opening remarks—I want to ask a question about Medicaid now—Dr. Wiener said that he thought we should expand eligibility and coverage of Medicaid. And I am asking each of the members of the panel, if they choose to offer an opinion, tell us whether they agree or disagree with that, and, if so, why they do or do not agree.

Professor ZIMMERMAN. I would say I would disagree at this point in time. I am not convinced that there is an argument for expanding the program. The program is close to $40 billion right now. Unless someone can come up and show what we are talking about in the way of expansion, who that expansion should be focused on, I would have to say I can't agree with it. We are talking about a lot of money. Any expansion amounts to a lot of money.

Senator MITCHELL. Dr. Altman.

Dr. ALTMAN. I would support it in the way that Karen Davis indicated. I think we, as we move the bill towards a national protection system of some kind, you should combine some form of employer mandate to pick up those people who are working with an expansion of the Medicaid state-run system to fill in that gap.

Looking at the dollars is a big, big, big mistake. Most of those dollars are going on the long-term care side. Most of the long-term care dollars are going now to people who have to spend down or figure out ways of getting rid of their money. So the people who we set up the Medicaid program are getting less and less.

I think Karen's statements and plan makes a lot of sense.

Senator MITCHELL. Which was to shift that aspect from Medicaid to Medicare?

Dr. ALTMAN. No. What she was suggesting—I will let her speak—but in terms of its combining an employer-based system to pick up those who are working, but expanding the Medicaid part of those people who aren't eligible for an employer-based one.

Senator MITCHELL. Dr. Davis.

Dr. DAVIS. I would just reinforce that I do think that expanding Medicaid in fact ought to be our top priority; that we can't even think about catastrophic expenses and not do something about the uninsured, for whom even modest expenses are catastrophic. So I would do three things. Put a minimum income floor in the Medicaid program. Start it wherever you think the budget will allow. Sixty percent of the federal poverty level. Say everybody below that level is automatically covered for Medicaid.

There are other things we could do. For example, we cover children up to age 5; that we haven't dealt with the children.

Senator MITCHELL. You would make it exclusively income based?

Dr. DAVIS. Yes. I would put a minimum income floor.

Senator MITCHELL. All right.

Dr. DAVIS. That is the first thing. And including looking at across the board without regard to categorical restriction.

The second thing that I think we need to look at in the Medicaid program is a fairly small provision that one said is a serious problem for certain groups, and that is something called spousal impoverishment that occurs when one person is in a nursing home and it drives the person in the home into poverty. And I think we need to remedy that in the Medicaid program.

And, third, I think we need to look at those who are above our minimum eligibility level and make Medicaid a provider of last resort, some type of catastrophic coverage, either by having people pay a sliding scale premium, as was mentioned earlier by Senator Chafee, perhaps up to 200 percent of the federal poverty level, or by just saying that once you have made a reasonable effort, paid 15 percent of your income or $2500.00, you are automatically covered by Medicaid for at least a year.

Senator MITCHELL. Dr. Meyer.

Dr. MEYER. Yes, I favor Medicaid expansion. First, like Karen, I believe in a federal floor on AFDC, which would bring a lot of people into Medicaid.

Second, I would uncouple further Medicaid from AFDC and SSI, particularly for SSI. They are not going to be covered by employers. The nation's elderly poor and disabled—in some cases they are disabled—but, generally speaking, they don't have that alternative. And I know that only half of the SSI eligibles participate. So they don't get Medicaid because they are not in SSI. And we should extend in a mandatory way the coverage to them.

On the AFDC optionally needy, like the unemployed, UP, I would mandate that and bring some of those people in.

For the working poor, I think some extensions could be achieved by relaxing the deduction limitation on work that have been so tightly drawn. But otherwise, I would consider something like a pseudo model. You know, one of the things we do in unemployment tax, you have to pay a tax, regardless.

We could say to employers, you either provide some coverage or you pay a tax into a fund, and that fund could help provide a catastrophic only or some limited benefit that doesn't look as good as what a good private sector plan, because you do have to worry about providing something so good that employers dump even low middle people back on.

So I think if there was a catastrophic type, high deductible plan in reserve for the working poor that employers had to contribute to, it might be a nice compliment to these other measures for the nonworker.

Senator MITCHELL. Dr. Palmer.

Dr. PALMER. Karen and Jack leave me a little to add, I think. I agree with the expansion. I think it is important. They have outlined a lot of the ways to do it. I would just emphasize that it seems to be the absolute highest priority is just building that national floor up. We have people at 15, 20, 30 percent of the poverty level who are not eligible for the Medicaid program in a lot of states in the country, and, on balance, less than half of the low income population non-elderly are. And it seems to me that that ought to be within the whole health care system. When I look at where we ought to put some additional dollars or reallocate them, that would be the very top priority.

Senator MITCHELL. Miss Polich.

Ms. POLICH. I also agree that we need to increase eligibility, create a federal floor, increase the state variation, which I think is very inequitable. Have some type of graduated eligibility or catastrophic coverage so that it is not an either/or, all or nothing program.

I would also suggest looking seriously at taking long-term care out of Medicaid. I think it creates a very schizophrenic program and takes away from what Medicaid really was, I think, initially intended to do, that being a program to provide care to poor families and children. And I think we need to get that set.

Senator **Mitchell**. Professor Reinhardt.

Professor **Reinhardt**. I would agree that the second best solution in a short run forcing employers to pay health insurance and expanding Medicaid would be better than what we have now, but I consider that second best because, as we have indicated, I am always ready to be inspected on the American way as an immigrant, but I am impressed that so far employer's health insurance has been voluntary, and voluntarism is an American way, and so is the encouragement of entrepreneurship. But I would in the long run not favor that route, but go a route with a federal fail-safe program for which every American is entitled, with defined benefits delivered through HMOs, where feasible, and pay for that through an income-related tax through the tax system, supplemented with earmarked taxes from a gasoline tax—that could easily be justified—or a tax on alcohol and tobacco.

I think such a system could involve the states, but it is to be federal for the simple reason, which maybe it is very simplistic.

I think I, in New Jersey, should be very much concerned what happens to an American infant in Texas, and what is done and not done for that infant. And I do not think it is fair to expose that infant to the oil price policy of Sheik Umani. But that is what is happening right now. And I think he is an American, they're my fellow citizens, and I should be happy as a New Jerseyite to contribute toward a pool that pays for poor Texans. And it, therefore, cannot truly be a wholly state matter.

And I have details that I would be happy to provide for the committee of how that might work.

Senator **Mitchell**. Would you please submit that in writing?

Professor **Reinhardt**. Yes, sir.

Senator **Mitchell**. I would appreciate that.

[The information not available at press time.]

Senator **Mitchell**. Dr. Rubin.

Dr. **Rubin**. I had the privilege to serve with Senator Evans on a committee to look into this, and I generally, as I indicated in my testimony, support the provisions in his bill which would expand Medicaid, in contrast to the recommendations of the other panelists. There is also a financing vehicle that would pay for all of these expansions, which are not insignificant.

So I think that, clearly, we need to expand and eliminate a lot of the disparities in the current Medicaid program. But I think that each time we do that, we need to be mindful as to how we are going to pay for it. And I am not sure that the income tax vehicle is the best way to do it.

Senator **Mitchell**. Dr. Wiener.

Dr. **Wiener**. If the federal government has any role in health care at all, it is in providing financing for health care for the poor. And it seems to me that that is what Medicaid is about, and that is something that Medicaid only does reasonably well right now. We need to do better, and I think that should be the number one priority.

Senator **Mitchell**. The Administration has proposed that the Part B Medicare premium be increased so that income derived from premium payments by beneficiaries would equal 35 percent of the cost to the program. As you now know, they are now 25 percent. That has been a matter of controversy for some time.

Each of you please tell me whether you agree or disagree with the Administration's proposal regarding new enrollees.

Mr. **ZIMMERMAN**. I think, again if we are trying to generate more revenue for the program, and the program needs it, then I would agree with that approach.

Dr. **ALTMAN**. Well I think we have discussed the value of beginning to think about it making it income-related. And as you begin to 35 percent, the dollars as a percentage of the low income side of the population begins to look very high. So while I am not opposed to it, I think it should be combined with some income-related aspect.

Senator **MITCHELL**. Thank you, Dr. Altman. Dr. Davis.

Dr. **DAVIS**. I oppose it. I think the elderly already spend over $1500 per person out of pocket on health care expenses, and any increase in that burden is simply not tolerable.

Senator **MITCHELL**. Dr. Meyer.

Dr. **MEYER**. I like relying more on premiums, but I don't like discriminating between new and current recipients or the lack of income relating. So I guess I would have to oppose this version.

Senator **MITCHELL**. Dr. Palmer.

Dr. **PALMER**. I would oppose it too. I think the burden again on the elderly of modest means is quite high. It is already about 20 percent that goes with their income for out of pocket expenses, even when you take Medicaid into account. And I think that there ought to be an increase in the cost, but those ought to be income related. And we should not push it up further across the board. We should start to move to the income-related route with the next step.

Senator **MITCHELL**. Miss Polich.

Ms. **POLICH**. I support increasing the portion of the program that is covered by beneficiaries, but I would be very cautious about increasing any burden on low income elderly. So as long as it is combined with some type of income adjustment that, in fact, reduces out of pocket payments or eliminates out of pocket payments for the poor elderly, I would support it.

Senator **MITCHELL**. Professor Reinhardt.

Professor **REINHARDT**. I also would be against burdening the low income any further than they already are. I think that burden is already too high now. If there is to be a contribution by the aged as a group, it could be income-related or asset-related.

I think Senator Heinz once had hearings on the potential of reversed mortgages, which the private market does not offer, but maybe the government could. The aged sits on some $600 billion of real estate, some of which could be liquidated through the reverse mortgages to pay for additional premiums that the other income has, but not at the lower.

Senator **MITCHELL**. Thank you.

Dr. Rubin.

Dr. **RUBIN**. As I indicated in my statement, I support increasing the premium; however, I would make it income-related and I would do it for all beneficiaries.

Senator **MITCHELL**. Dr. Wiener.

Dr. Wiener. The program clearly needs more revenues. I think this is not the way to do it. Some other kind of tax increase that could be geared towards the elderly, I think, is a desirable way to raise the money. But as Karen and others have indicated, an across the board approach is not the way to go.

Senator Mitchell. Thank you.

Dr. Rubin, would you share with us your thoughts on the peer review organizations, the PROs, and how you think they have worked, what suggestions you have with respect to that program?

Dr. Rubin. Well, my sense of the peer review organizations that I am familiar with is that they, in essence, have become cost containment tools that are driven almost exclusively by their contractural obligations to save money; that they really have not done what one of the roles that was envisioned for them, which was to focus on the quality of care received. They are into the business of denial of care or changing the site of care in somewhat arbitrary, and in some respects, capricious ways, depending on which PRO we are talking about across the country.

I think they are, in general, underfunded, although the Inspector General suggested that some of them made substantial profits during their first few years of operation.

If you look at what they spend per beneficiary, that is a pretty good deal relative to what private peer review would cost. For example, if our company wanted to have the same kind of review done, it would cost us more.

I think that there is clearly areas for improvement. I think that they need to be given the tools so that they can do better quality reviews, rather than merely being gate keepers of the worst sort.

Senator Mitchell. Does any other member of the panel want to comment in response to that question? Mr. Zimmerman?

Mr. Zimmerman. Senator, I would basically agree with those remarks, and add that it is still a relatively new program in terms of activities in the Medicare program. And I think the Administration, at least our evidence has been, is trying to get that program up and running as best as possible. I think it has got a way to go. They know it. But I am surprised as to how well it is doing considering the problems that the PSRO program had, which it replaced.

Senator Nitchell. Dr. Altman?

Dr. Altman. I would just add that I do think that there are much better mechanisms out there in the private side than we are using on the public side. I think we changed the PRO program from the PSRO program, but it still has that basic structure at the top down. I think there is much more mechanization that could go on through precertification programs that are being done on the private side, through high cost case management. I don't think they are doing that. And, therefore, they are doing it very expensively. And I do think they are learning, and are moving to the quality side, but they were set up to be cost control and they have not been funded well for that from the quality side.

Senator Mitchell. Dr. Wiener.

Dr. Wiener. I think we need to be cautious on what we want the PPOs to do. There has been a lot of interest in having them move into areas outside of the hospital. I don't think they know much about the delivery system outside of the hospital. They don't know about the care that is needed there, and they don't have the technologies in place to evaluate them.

So I think we need to be more cautious than we have been recently in thinking about what the role of PROs should be outside of the hospital.

Senator **Mitchell**. Does anybody else with to comment on that?

(No response)

Senator **Mitchell**. If not, I would like to ask each of you to submit in writing, if you care to do so, your thoughts on how specifically, either the current PRO program can be improved, or any alternative method for achieving the objectives that the Congress sought in creating the current system.

[The information not available at press time.]

Senator **Mitchell**. Dr. Wiener, yesterday at the hearing in this room on catastrophic coverage, Dr. Bowen said that four out of five elderly persons in need of long-term care now receive that care from their families or friends at no cost to the public. And yet the remaining 20 percent constitutes a major problem, a major expenditure in terms of the individuals and the nation. You have been studying this for some time.

Should we not be concerned about the problem of what will occur if we create a program that establishes some form of inducement to the 80 percent of the families now performing this as a part of the family to participate in a publicly-funded program?

I believe Mr. Zimmerman and Dr. Altman both made reference to the enormous cost associated with this entire problem.

Is that a major concern? Can a program be structured, given that reality?

Dr. **Wiener**. I think it is a major concern, but having been in the field now for 10 years, I am not quite as worried about it now as I was perhaps earlier. I think there is very little evidence to suggest that financial considerations are what lead people to place their relatives in nursing homes. What you have is a very, very high level of effort by people to try to keep their relatives at home. The issue of substitution of formal services is more serious on the home care side, but when the HHS channeling demonstration was set up, they had a fair amount of difficulty finding people to enroll in the program.

I think the way to handle it is to try to target the people who are eligible for services, try to limit the pool of people to a manageable size, say, people with more than three problems with activities of daily living. I think we clearly need cost sharing to keep the cost down.

I think it is a risk, and there will clearly be some increase in utilization on both the nursing home and home care side if we go to a more generous program, but I also think that if we are smart enough to prefund it, it will be manageable.

Senator **Mitchell**. Thank you.

Before concluding, I wanted to ask each of you if you have a very important unuttered thought that you feel has not been made, to give you an opportunity to make it now, or to say it now, if there is something you feel, a point that has not been made that is burning within you to get out, if you would like to make it.

Mr. Zimmerman.

Mr. **Zimmerman**. Senator, yes, sir. One of the issues in my testimony dealt with rebasing the prospective payment system. My office has taken a position over time that that is important and necessary. The data that is in the system goes back to 1981 pretty much. We believe it is obsolete and, to some degree, inadequate. We think it would go a long way to eliminating some of the guess work that is in the current system. And I think it is a necessary step.

We are paying some $50 billion a year based on a system that no one really knows what the cost of health care is anymore.

Senator **Mitchell**. Thank you.

Dr. **Altman**. We would support that at ProPAC.

Senator **Mitchell**. All right.

Dr. Davis, do you have a comment? I am not trying to induce closing statements, but if someone has something that they want to say.

Dr. **Davis**. I don't think we have stressed enough the inadequacy of the Medicare home health benefit, the restrictions that apply to the home ban, limiting it to those who only need intermittent care, requiring the services of a skilled nurse. I think as we are discharging patients sooner, we need to look at liberalizing the Medicare benefit.

And then, finally, I would say about the informal care being rendered by families, we need to think about respite services for those, particularly with Alzheimers or related diseases, which are an enormous burden on families to try to meet.

Senator **Mitchell**. Thank you.

Dr. Palmer.

Dr. **Palmer**. Nothing more.

Senator **Mitchell**. Miss Polich.

Ms. **Polich**. I guess I would like to make both a comment and an observation related to catastrophic care, interesting catastrophic care right now.

I am somewhat concerned that our strong interest in catastrophic care and the potential that something might be enacted this year may mask other problems within both Medicare and Medicaid and prevent us from acting on that.

Catastrophic care, the proposal that is before us now in the form of Secretary Bowen's plan, does not, by any means, solve, I think, the primary problems with Medicare and Medicaid. And I don't want us to lose sight of those problems in examining his proposal.

Second, I wanted to make just an observation that I think there is a very strong relationship between managed care systems and catastrophic care and catastrophic coverage.

Right now, Medicare beneficiaries and HMOs are, by and large, covered for catastrophic expenses. They have lower premiums—in the Twin Cities, an average of about 10 to 15 dollars a month—that have expanded benefits: preventative examinations for eye glasses, hearing aides, prescription drugs, many things that Medicare does not cover, with no co-payments or limited co-payments; no deductible; limited paperwork; and no coverage limit.

I think that that is important to recognize, particularly also when we were evaluating capitation rates, because while I think the literature strongly shows that Medicare covers only about half of the expenses for the elderly, HMOs and managed care systems generally cover all costs. And I think we need to be looking at that too when we are looking at catastrophic.

Again, a movement toward managed care systems will accomplish a lot of what we want to accomplish in catastrophic care.

Senator MITCHELL. Thank you very much.

Professor Reinhardt.

Professor REINHARDT. I would like to urge us in thinking about health insurance policies in this country not to get too hung up on this notion of two-tier health care versus one-tier health care. I think that is a rhetorical luxury that the nation's poor can ill-afford.

The truth is that this country has always run a two-tier health care system, and I would just it be quite brutal in aspect. And what we are really talking about is replacing that system with a more humane two-tier system. But the dream of one-tier health care in America is expensive. We have said for the poor nothing but the best, and then when the best was too expensive, we just gave them nothing. And I think that has been the cross the poor had to bear.

I think when I talk about multi-tier, or two-tier, one has in mind really the degree of choice among providers sundry income classes will enjoy. I think it will come to past that when we ultimately solve these problems that we discussed that poor Americans will have their choice of provider somewhat limited to, say, HMOs, and well-to-do Americans will purchase for themselves indemnity policies that give them wider choice.

I think we should openly acknowledge this, and then try to be sure that the worst experience in America is the best in the world. And I think that can be done.

Senator MITCHELL. Thank you.

Dr. Rubin.

Dr. RUBIN. The observation that I would like to make is that I was pleased and somewhat surprised to find that across virtually all of the questions that you asked, there was a substantial degree of unanimity, perhaps not in terms of all of the fine points of the programs, but in terms of the general thrust in both Medicare and Medicaid. And I think that goes well for your subcommittee's efforts to fashion some positive changes in the system, and to see them implemented in the near future.

Senator MITCHELL. Thank you, Doctor.

Dr. Wiener.

Dr. WIENER. I just want to say a couple of final words about the acute care portion of Secretary Bowen's proposal. It seems to me that the debate on that has been mistakenly framed as a conflict between whether the public sector should provide supplemental insurance or whether the public sector or the private sector should provide it. This means that catastrophic coverage is going to replace Medigap coverage. The fact of the matter is that very few people will meet that $2,000 out of pocket payment. They need the protection, but very few people are going to meet that limit. The bulk of Medigap coverage is for the first dollar deductible and 20 percent co-insurance, for fairly low levels of expenditures. I would expect that the elderly will go out and buy Medigap insurance with the same vengeance that they have for the last 15 years. The elderly don't like to pay out of pocket for their health care cost.

So I think there is going to be plenty of Medigap insurance left. The idea that we are going to wipe out the Medigap industry with this very modest catastrophic public program is simply wrong.

Senator **MITCHELL**. Thank you, Dr. Wiener.

Thank you all, ladies and gentlemen, for a very informative hearing. The hearing is closed.

[Whereupon, at 12:40 p.m., the hearing was concluded.]

Public Employees Retirement Association of Minnesota
Suite 200 — Skyway Level
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St. Paul, Minnesota 55102
612-296-7460

February 5, 1987

Mr. William J. Wilkins
Committee on Finance
Room SD-205, Dirksen Senate Office Building
Washington, DC 20510

Dear Mr. Wilkins:

The Senate Committee on Finance is currently reviewing President Reagan's 1988 budget submission to Congress which includes a provision to expand Medicare coverage to include public employees who are not currently covered. This proposal would have serious financial effects for many of the public employees and their county and local governmental employers that pay into the funds administered by PERA of Minnesota. The PERA Trustees want the members of the committee to be fully aware of the extent of these financial effects. They believe that a Medicare coverage expansion should not be agreed to simply because it happens to raise federal government revenue.

There are currently 10,771 county, local, and school district employees who are covered under two of the pension funds that PERA administers. Since these two funds are not integrated with Social Security, these employees do not contribute to Medicare. An expansion of coverage to include them would add an additional 1.45 percent of payroll to the 8 percent that these employees are already required to pay into the PERA funds under State law.

The chart below indicates what the dollar cost would be for each employee group if they were required to make payroll tax contributions to Medicare. The cost to their governmental unit employers would be identical.

	No. of Employees Affected	Covered Payroll	Cost Per Year
County Employees	3,596	$101,440,411	$1,470,886
City Employees	4,977	132,719,436	1,924,432
School District Employees	2,198	36,844,210	534,241
TOTAL	10,771	$271,004,057	$3,929,559

Not only would this proposal cost Minnesota's county and local public employees and their governmental employers a significant amount, but the benefit to be derived from Medicare coverage would be of doubtful value. Unless the past public service of employees who are not currently covered under Medicare were credited for Medicare eligibility purposes, those employees who are approaching retirement would be forced to pay in but would end up with too few years of covered employment to be eligible for Medicare benefits. Moreover, even those who are more remote from retirement may derive no measurable benefit since most of them would already be eligible for Medicare through a spouse who works in Social Security covered employment.

The PERA Trustees are aware of what was done in terms of mandating Medicare coverage for federal employees in years past. First, new hires were covered; then, current employees were covered, although in the process of covering current employees their past service was credited for Medicare eligibility purposes. But what was done with respect to federal workers was done not to assure that they would have adequate health care benefit protection in old age but simply to raise federal government revenue.

With respect to state and local public employees, we see the same Medicare coverage extension pattern evolving and for the same reasons. We, therefore, reiterate that this proposal would impose a new and significant tax load on county and local public employees whose combined federal and state tax burden is already high in Minnesota. In addition, it would further impair the financial health of the state's governmental subdivisions that have already suffered drastic reductions in federal and state aid.

The PERA Trustees urge you to keep these points in mind as you consider the merits of the Medicare coverage extension proposal.

Sincerely,

James M. Hacking
Executive Director

JMH/sk

Connecticut Association of Boards of Education, Inc.
331 Wethersfield Avenue, Hartford, CT 06114 203-522-8201

February 10, 1987

To: The Honorable Members Of The Committee On Finance Of The United States Senate

From: The Connecticut Association of Boards of Education

Re: The President's Budget Proposal To Extend Medicare Coverage To All Local And State Employees

Last week you received a copy of our comments to the Senate Finance Committee. This is an addendum to those comments.

The statewide cost in Connecticut of the employer contribution for Medicare Tax for all certified staff, based on current payroll figures, would be in excess of $23 million. The future costs could dramatically increase because of "enhanced" teacher salaries. The attached survey of Connecticut school districts illustrates the impact of the extension of Medicare coverage to all certified school district employees.

In lieu of social security and medicare benefits, Connecticut provides teachers with a generous state teacher retirement system which includes health insurance benefits. In addition, local school districts are mandated by the state to allow retired teachers to be covered in local teacher health insurance plans. Also, many school districts have contracted to provide other important benefits to teachers.

The federal mandated Medicare Tax effort is an effort to boost federal revenues at the expense of local property taxpayers. Because the only revenge that the average citizen feels he can take against what he sees as overtaxation, is at the local level where he can vote down local tax increases to pay for schools and other local services, public school students will be the ones to suffer the consequences of this new tax twist.

The Connecticut Association of Boards of Education urges the Committee to reject the President's budget proposal to extend Medicare coverage to all local and state employees.

PM/gc

Attention: William J. Wilkins, Counsel
Committee On Finance

Connecticut Association of Boards of Education, Inc.
331 Wethersfield Avenue, Hartford, CT 06114 203-522-8201

Cost of Extending Medicare To Certified Teachers And Administrators In Connecticut School Districts By Congressional District

1st District

Berlin	$ 74,573
East Hartford	253,389
Manchester	227,650
Newington	169,708
Rocky Hill	71,729
West Hartford	351,385
Wethersfield	128,392
Windsor	155,887

2nd District

Bolton	$ 25,095
Canterbury	14,602
Coventry	53,251
East Lyme	98,381
Ellington	75,579
Griswold	42,091
Ledyard	114,136
Lisbon	11,013
Middletown	155,451
New London	128,289
Plainfield	80,398
Preston	17,564
Salem	11,041
Stonington	72,550
Vernon	160,741
Voluntown	5,666
Willington	21,885
Chester, Deep River, Essex (Reg. 4)	68,205
Durham, Middlefield (Reg. 13)	59,967

3rd District

Clinton	78,306
East Haven	114,467
Guilford	111,001
Madison	96,860
North Branford	70,146
North Haven	127,692
Orange	41,218

4th District

Bridgeport	$637,776
Darien	144,863
Fairfield	301,990
Stamford	594,529
Trumbull	188,732
Westport	216,956

5th District

Brookfield	$ 84,535
Derby	42,657
Meriden	269,408
Monroe	109,185
Newtown	122,705
Oxford	33,268
Ridgefield	172,322
Seymour	64,205
Shelton	151,429
Trumbull	188,732
Waterbury	507,500
Wilton	129,340
Middlebury (includes Southbury- Reg. 15)	101,521

6th District

Avon	$ 78,300
Litchfield	5,080
New Fairfield	97,677
New Hartford	14,088
Plymouth	61,625
Sherman	9,768
Simsbury	157,735
Somers	45,575
Suffield	62,125
Thomaston	30,497
Warren, Morris, Goshen (Reg. 6)	38,524
Southbury (includes Middlebury- Reg.15)	101,521

LO/gc
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